



# LEGACY SCHOOL™

B A N G A L O R E

## HEALTH & MEDICAL QUESTIONNAIRE 2019 - 20

Parent 1

Parent 2

Emergency  
Contact  
(Other than the parent)

Child

### EMERGENCY CONTACT INFORMATION

Family Doctor : \_\_\_\_\_ Mobile : \_\_\_\_\_

Preferred Hospital / Clinic : \_\_\_\_\_ Phone : \_\_\_\_\_

Insurance Provider \_\_\_\_\_ Policy No. \_\_\_\_\_ Expiration \_\_\_\_\_

Parent 1 : \_\_\_\_\_ Mobile : \_\_\_\_\_  
*First Name Last Name*

Parent 2 : \_\_\_\_\_ Mobile : \_\_\_\_\_  
*First Name Last Name*

Local emergency contact : \_\_\_\_\_ Mobile : \_\_\_\_\_  
*(Other than the parent) First Name Last Name*

Home Address : \_\_\_\_\_  
*House / Apartment Number and Name Street Address*

\_\_\_\_\_ *Town / Area City State / Province Postal / Zip Code Country*

### VACCINATION RECORD

Vaccine	Vaccine Dates				
BCG					
Chicken pox					
Hepatitis A					
Hepatitis B					
Measles					
Mumps					
Rubella					
Polio					
Tetanus					
Other _____					

Student Name : \_\_\_\_\_  
 Grade : \_\_\_\_\_  
 Gender : \_\_\_\_\_  
 Date of Birth : \_\_\_\_\_  
 Blood Type : \_\_\_\_\_

**CONFIDENTIAL**

Please indicate below if your child has experienced or is still experiencing any of the following?

Allergies (Mild)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Allergies (Severe)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anxiety / Panic attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Skin allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cardiac related illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hearing impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Visual impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hypertension / Stress	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Speech impediment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Respiratory illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Neuromuscular condition	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Physical challenges	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Emotional difficulties	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Behavioural challenges	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Any Other (please specify)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____		

Is your child allergic to any medication?  No  Yes

Can your child be given any medication by the school for common illnesses?  No  Yes

Does your child take any prescribed medication regularly?  No  Yes

Have your child's developmental milestones been age appropriate?  No  Yes

Is there any other important information concerning your child's health?  No  Yes

List any special dietary needs / preferences : \_\_\_\_\_

**Note :** Please provide additional details on a separate sheet pertaining to any medical conditions or challenges (if applicable)

**DISCLAIMER :**

- The information provided above is certified to be true to the best of our knowledge.
- In the event of a learning or behavioural challenge, the school would request for a professional evaluation report to be submitted.
- In the event of an emergency, we authorize Legacy School to take any action that is deemed to be in the best interest of our child in consultation with the medical practitioner concerned.
- We agree to reimburse Legacy School for any medical treatment that our child may receive.

**Name of Parent 1 :** \_\_\_\_\_ **Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Parent 2 :** \_\_\_\_\_ **Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Note:** This form is to be completed and submitted along with the student's application form at the time of admission.