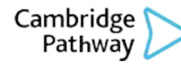

Cambridge International School

LEGACY SCHOOL™

BANGALORE

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 __________					

LSB
LEGACY SCHOOL™
BANGALORE

CONFIDENTIAL

Student Name : ____________________

Grade : ____________________

Gender : ____________________

Date of Birth : ____________________

Blood Type : ____________________

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

Allergies (Mild)	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Allergies (Severe)	☐ No	☐ Yes	Anxiety / Panic attack	☐ No	☐ Yes
Skin allergy	☐ No	☐ Yes	Cardiac related illness	☐ No	☐ Yes
Hearing impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Visual impairment	☐ No	☐ Yes	Hypertension / Stress	☐ No	☐ Yes
Speech impediment	☐ No	☐ Yes	Respiratory illness	☐ No	☐ Yes
Neuromuscular condition	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Physical challenges	☐ No	☐ Yes	Emotional difficulties	☐ No	☐ Yes
Behavioural challenges	☐ No	☐ Yes			
Any Other (please specify)	☐ No	☐ 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.