



AJJAL Al Khamsa Kindergarten
روضة وحضانة اجيلال الخامسة

Ajjal Al Khamsa Kindergarten affiliated with

Modern Montessori Kindergarten



Affiliated With بالتعاون مع
MODERN
MONTESSORI
KINDERGARTEN

Student Medical Form

Name of Student: Gender:

Blood group: Class\Section:

Date of Birth: Father's Profession:

Father's Mobile No.: Father's Work Phone No.:

Home Phone: Mother's Profession:

Mother's Mobile No.: Student's National No.:

Email:

Residence Address:

In case of emergency contact this person when parents cannot be reached:

Name: Home Phone No.: Mobile No.:

Name of Physician: Clinic Phone No.: Mobile No.:

Did your child contract any of the following?

	Yes	No	Date
Mumps			
Chicken Pox			
German Measles			
Rheumatic Fever			

Does he\she suffer from one of the following? If so, please clarify or provide medical report.

	No	Yes
Diabetes		
Epilepsy		
Heart Conditions		
Asthma		
Use of inhaler \ if yes , please provide school with one		
Migraine		
Bone and joint diseases		
Fainting attacks		
Any other diseases \ please specify :		

	No	Yes
Any surgical operation? If so, please detail:		
Any serious illness or accident?		
Sight problems		
Hearing problems		
Speech problems		
Any behavioral problems?		
Any allergies? If so, define.		
Any health condition that needs to be reported to school?		
Any physical or psychological reason that needs school or doctor's attention?		
Any reason for not participating in physical activities?		

- **Should your child have a condition, which requires regular prescribed medication, or be taking medication which may cause serious side effects, please make sure that the school doctor is informed.**

Please Note: Parents are responsible for the vaccination of their children. Children must take boosters at 6, 10, and 15 years of age.

Please check with your doctor before signing this form.

I, the parent of :....., confirm that my son\daughter has taken all the required vaccinations.

Parent's Name: **Parent's signature:**

Date: