



Student Medical Form

British International School of Wrocław

Student's Name:

Date of Birth: - - Sex:

Nationality:

Childhood diseases:

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Serious injuries, surgery or illness in the past:

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Allergies:

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Chronic conditions (if your child takes medicine regularly please specify name and times given):

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Eyesight and hearing condition (glasses, contact lenses, hearing aid):

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IMMUNIZATION RECORD

	Dates of vaccinations					
<i>Hepatitis A</i>						
<i>Hepatitis B</i>						
<i>TB Test</i>						
<i>Polio</i>						
<i>Diphtheria</i>						
<i>Mumps</i>						

Signature:

Date:

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