



# HEALTH QUESTIONNAIRE

## Student's Personal Information (To be completed by the parents)

Family/Last Name: \_\_\_\_\_ Given Name(s): \_\_\_\_\_

Gender: Male  Female

Date of Birth (dd/mm/yy): \_\_\_\_\_ Age \_\_\_\_\_ Religion(if any): \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Nationality: \_\_\_\_\_ First Language: \_\_\_\_\_

Emergency Instructions: \_\_\_\_\_

## Student's Medical History (To be completed by the parents)

1. Please describe any medical condition(s) or health history of your child that CIS should be aware of, i.e. epilepsy, diabetes, asthma, allergies: \_\_\_\_\_  
\_\_\_\_\_

2. Does your child take any form of medication (oral or injected) on a regular basis for any of the above?  Yes  No  
If 'Yes', please provide full details: \_\_\_\_\_  
\_\_\_\_\_

The school will not administer any medication without the express consent of a parent. If you wish to have medication administered to your child at school, arrangements must be made in advance and a signed note from the parent and the doctor must be provided.

3. Does your child have any vision problems?  Yes  No  
If 'Yes', please describe: \_\_\_\_\_  
\_\_\_\_\_

4. When was your child's vision last checked (dd/mm/yy)? \_\_\_\_\_

5. Does your child have any hearing issues?  Yes  No  
If 'Yes', please describe: \_\_\_\_\_  
\_\_\_\_\_

6. Are there any special food allergies or special food considerations?  Yes  No  
If 'Yes', please describe: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Name & Signature

\_\_\_\_\_  
Date