STUDENT HEALTH QUESTIONNAIRE

Please provide any information on medical conditions or concerns of which CIS should be aware.

Student Personal Information

Legal Name Family Name/Surname	First Name	Middle Name (if applicable)	Preferred Name:
☐ Male ☐ Female	**Date of Birth (dd/mm/yyyy)**	**Religion (if any)**	

Student Medical History

1. Please describe any medical condition(s) or health history (past and recent) of which CIS should be aware. Please also attach relevant documentation, if any.

   _____

   _____

2. Does your child take any form of medication (oral or injected)? ☐ Yes ☐ No
   If 'Yes,' please provide full details and attach relevant documentation, if any: _____

   _____

   _____

   How long has this medication been taken? Since (mm/yyyy): _____

Please note: The school will not administer any medication without the expressed consent of a parent or guardian. If you wish to have medication administered to your child at school, arrangements must be made in advance and a signed *Medical Administration Form* must be provided.

3. Does your child have any special foods allergies or special food considerations? ☐ Yes ☐ No
   If 'Yes,' please describe: _____

   _____

   _____

4. Does your child have any vision problems? ☐ Yes ☐ No
   If 'Yes,' please describe: _____

   _____

5. When was your child's vision last checked (dd/mm/yyyy)? _____
6. Does your child have any hearing issues? ☐ Yes ☐ No
   If 'Yes,' please describe: _____

   _____

7. Has your child seen a dentist in the last year? ☐ Yes ☐ No
8. Does your child have any physical disabilities? ☐ Yes ☐ No
   If 'Yes,' please describe: _____

   _____

   _____

Emergency Medical Instructions

1. In case the parent(s) or guardian(s) are not reachable in a medical emergency, please indicate the details of additional contacts:

Emergency Contact 1		
Full Name:	Relationship to student/family:	Phone number:
Emergency Contact 2		
Full Name:	Relationship to student/family:	Phone number:

2. Special medical emergency instructions? Please provide specific information, phone numbers, etc._____

_____

3. Preferred doctor? Please provide full name, contact information, etc. _____

_____

4. Preferred hospital or clinic? Please provide name, address, contact information, etc. _____

_____

_____	_____	_____
Parent/Guardian Name (PRINT)	Parent/Guardian Signature	Date (DD/MM/YYYY)