المدرسة الأهلية
AHLIA SCHOOL
BAHRAIN

Health History Report

Family Name:_____ First Name_____ Middle Name: _____

This information is to be completed and signed by parents and returned to the homeroom teacher. It will then be placed on file in the Clinic. The information will be kept in complete confidence.

1. Does your child generally seem to be in good health?
   _____
2. Do you believe that your child can participate in regular physical education classes? **Yes [ ] No [ ]**
3. **a)** Is your child currently taking any kind of medication?
   _____
   b) If so, what kind?
   _____
   c) For what purpose?
   _____
4. **a)** Is your child allergic to any kind of medication or foods? **YES [ ] NO [ ]**
   b) If so, please specify.
   _____

Please circle below any of the following condition/conditions that your child may have.

Skin Disease	Asthma	Convulsive Seizures	Diabetes
G6 PD	Hemophilia	Heart Problems	Hearing Defects
Epistaxis	Sickle Cell Disease	Speech Problems	Vision Defects
Sinus Conditions	Thalassemia	Allergies**(ex.):**_____	

5. Can the school administer (Panadol) to your child in the event of a headache or fever? **YES [ ] NO [ ]**

Please indicate below emergency contact numbers in the event that we need to reach you.
(Please provide at least 3 Telephone Numbers.)

	Name	Phone Number
Father's		
Mother's		
Other		

Thank you for your cooperation.

Parent's Signature: _____

Ahlia School Nurse: _____