CISA
Cedars International
School of Angola

STUDENT MEDICAL INFORMATION

FOR OFFICE USE ONLY	
Date	
File №	

BLOOD TYPE	

Photo

Last Name: ____________________

First Name: ____________________

Date of Birth: d d / m m / y y y y   Age: ________   Gender: Male ☐   Female ☐

Family doctor information: (if available)

Full Name	Phone Number(s)	Address

Parents Information:

	Father / Guardian	Mother / Guardian
Full Name		
Phone Number		
Business Number		
Work Address		

Contacts to call in case of emergency when parents cannot be reached:

Full Name	Phone Number(s)	Relation	Address

General Health Information's:

- Any learning or behavioral issues?

Dyslexia ☐ ADD/ADHD☐ Behavioral Needs ☐ Learning Difficulties ☐ Other☐
Specify____

- Any concerns about general health?

If yes specify: ____ ☐ Yes ☐ No

- Any prescription medication (daily or occasionally)?

If yes specify: ____ ☐ Yes ☐ No

- Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?

If yes specify: ____ ☐ Yes ☐ No

- Any hospitalization, operation, or major illness?

If yes specify: ____ ☐ Yes ☐ No

- Any allergies (food, insects, medications, etc.)?

If yes specify: ____ ☐ Yes ☐ No

____

____

____

I confirm and assume responsibility for the information provided on this form to be true, complete, and accurate, and I understand that the school reserves the right to dismiss the student without any refund if the information proves to be inaccurate.

Full Name: ______________________ Date: __________ Signature:

Relation to Student: ____