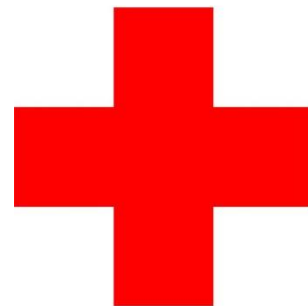
CISA
Cedars International School of Angola



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:

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? ☐ Yes ☐ No

If yes specify: _______________________________________

- Any prescription medication (daily or occasionally)? ☐ Yes ☐ No

If yes specify: _______________________________________

- Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)? ☐ Yes ☐ No

If yes specify: _______________________________________

- Any hospitalization, operation, or major illness? ☐ Yes ☐ No

If yes specify: _______________________________________

- Any allergies (food, insects, medications, etc.)? ☐ Yes ☐ No

If yes specify: _______________________________________

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I confirm and take responsibility of the information given in this form that they are true, complete and accurate.

Full Name: ______________________ Date: __________ Signature:

Relation to Student: _______________________________________