

STUDENT HEALTH RECORD DOCTOR'S REPORT

Health Examination to be completed by the student's Doctor. Please, submit this form along with the Application for Admissions form.

Student's Name: _____	Doctor's Name: _____
Date of Birth: _____ <small style="text-align: center;">Day / Month / Year</small>	Address: _____ _____
Date of Examination: _____ <small style="text-align: center;">Day / Month / Year</small>	Tel No: _____

Please tick the boxes which apply to the child being examined.

System	Normal	Abnormal	Health Problem	Yes	No
Heart/lungs	<input type="checkbox"/>	<input type="checkbox"/>	Hospital admissions	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>
Spleen/liver	<input type="checkbox"/>	<input type="checkbox"/>	Physical disability	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/mental/behavioural difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Eyes/vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	Dietary/eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/teeth/gums	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
Ears/hearing	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Bone/joint injury	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Growth/weight	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>

Please give details of any abnormalities or health problems:

Thank you.

Doctor's signature and stamp: _____

Date: _____