

Please complete this form and obtain a declaration of fitness from your General Practitioner (section B).
Please note that discovery of false or incomplete information may jeopardize your child's right to remain at the school.

SECTION A: To be filled in by a Parent or Guardian (Please print or type)

Child's family name _____ First name _____ Address: _____
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HISTORY OF CHILDHOOD DISEASES

Please mark the appropriate box if your child has had the following illnesses, and provide details, as indicated:

Infections

- | | | |
|--------------------------|-----------------------------|-------------------------------------|
| Measles | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| German Measles | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Scarlet Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Chicken Pox | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Mumps | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Infectious Mononucleosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |

Additional Comments: _____

HISTORY OF INFECTIOUS DISEASES

Please indicate whether you child has ever contracted, or been in contact with, the following:

Infection

- | | | |
|----------------------------|-----------------------------|-------------------------------------|
| Hepatitis A | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Hepatitis B | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Hepatitis C | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Typhoid Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Diphtheria | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Tetanus | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Poliomyelitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Malaria | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Bacterial/Viral Meningitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Endocarditis | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Tuberculosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| Giardiasis | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |

Please give details of recent exposure to any other contagious disease and any additional comments.

Child's family name _____ First name _____

OTHER ILLNESSES OR HEALTH CONCERNS

Please indicate if your child has ever suffered from any of the following, and give dates and details:

System:	Condition:	Dates and Details
Respiratory:	Frequent tonsillitis	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Otitis (frequent ear infections)	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Bronchitis	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Digestive:	Gastric, digestive or intestinal problems	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Recurrent diarrhoea	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Recurrent constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Cardiac/Circulatory:	Heart murmurs (congenital or acquired)	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Peripheral circulatory problems (chilblains, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Varicose veins	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Haematological:	Anaemia	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Prolonged or excessive bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Tendency to bruising	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Neurological:	Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Tetany	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Skeletal:	Rheumatoid Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Trauma to joints requiring treatment	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Bone injuries/conditions	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Endocrine:	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Thyroid or Parathyroid dysfunction	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Metabolic:	Obesity	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Failure to thrive	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Eating disorders e.g bulimia, anorexia	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Dermatological:	Eczema	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Psoriasis	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Urticaria	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Acne (if being treated give details)	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Other skin conditions	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Allergies:	Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Foods	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Hayfever	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Other airborne agents (please specify)	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Urinary:	Renal problems	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Cystitis	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Enuresis	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Gynaecological:	Dysmenorrhoea (painful periods)	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Irregular periods	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
	Other problems	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____

If you have ticked any of the above conditions, please give further dates and details of treatment, duration of treatment, if this is an ongoing concern. Where appropriate, include copies of medical documentation and certificates as well as a copy of the prescription for any medicine to be taken on a regular basis. All documentation should be in English or French where possible.

SECTION B: To be filled in by a General Practitioner (Please print or type)

Child's family name _____ First name _____
 Date of birth (Day/Month/Year) _____

Our regular school programme involves frequent outdoor expeditions, in all weathers, and on all terrains, and is, by general school standards, unusually strenuous. A good level of fitness is required, and this is maintained throughout the school year. Students unable to fully participate in the expeditions programme may not be considered for entry to Aiglon College. Please pay particular attention to the health of the spine and joints, (especially the knees), the cardio-respiratory system, and level of general fitness when examining the students prior to admission.

Please indicate whether the child is fully fit and able to participate in all sports and expeditions, without restriction.

YES NO

If NO, please state the type of restriction, and supply medical certificate to this effect. Please note that depending on the restriction made, admission to Aiglon may be refused on medical grounds.

IMMUNISATIONS AND VACCINATIONS

Please give dates, **and attach certificate**. Please ensure that the certificates are legible:

Name	1st dose	2nd dose	3rd dose	Booster	Booster
Diphtheria	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
Pertussis (Whooping Cough)	_____	_____	_____	_____	_____
Measles	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella (German measles)	_____	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
Yellow fever	_____	_____	_____	_____	_____
TAB (Typhoid & Paratyphoid)	_____	_____	_____	_____	_____
Meningitis C	_____	_____	_____	_____	_____
HPV (Human Papilloma Virus)	_____	_____	_____	_____	_____
BCG (Tuberculosis)	_____	_____	_____	_____	_____

Reaction to tuberculin skin test: Date _____ positive negative never done

Details of other vaccinations and immunisations that this child has received.

Child's family name _____ First name _____

RELEVANT DETAILS OF PHYSICAL EXAMINATION

E.g. Height, weight, blood pressure, heart rate, urinalysis, blood tests, etc.

RELEVANT FAMILY HISTORY

DETAILS OF ANY REGULAR MEDICATION

Please include a copy of the prescription and any specific instructions

Is this child currently taking or has ever taken: Prozac Ritalin Aderol
 Other cerebral stimulants or anti-depressants: _____

DRUG ALLERGIES Please specify allergen and reaction experienced:

OPERATIONS Please give dates and details

ACCIDENTS Please give dates and details

PSYCHOLOGY

Has this child had any psychological or emotional problems, received counselling, or been treated for depression/ADHD/ADD. (Please specify and attach report)

DENTAL HEALTH Condition of teeth: _____

Necessary supervision: _____

VISION Must this child wear: glasses or contact lenses (Please supply prescription)

I, the undersigned, confirm that I have thoroughly examined the above-named child, and declare that, to the best of my knowledge, the above information is correct.

Signed 

Practice stamp:

Doctor's Name in Capitals _____ Date _____