Newton British Academy
Al Dafna
"An international community of learners for excellence and celebrating success"

MEDICAL FORM

Joining Date	Year/Class

Full Name				Attach Passport Photograph Here
Gender	☐ MALE ☐ FEMALE			
Date of Birth				
Blood Group				
Father's Name				
Work or Home Tel. No.		**Emergency No.**		
Mother's Name				
Work or Home Tel. No.		**Emergency No.**		

PERSONAL HEALTH HISTORY		
Childhood Diseases	☐ Measles ☐ Mumps ☐ Poliomyelitis ☐ Chicken Pox ☐ Meningitis	
Medical Illness	☐ Asthma	**Allergies: Please state**
	☐ Kidney problem	☐ Medicine _____
	☐ Epilepsy	☐ Food _____
	☐ Heart Problem	☐ Others _____
	☐ Urinary Disorder	**Error of Refraction (Sight)**
	☐ Cancer	☐ With Corrective Glasses
	☐ Diabetes	☐ Without Corrective Glasses
	☐ G_6PD	**Other Medical Illness: Please state**
	☐ Nose Bledding (Epistaxis)	_____
	☐ Hearing Problem	_____

Is your child taking any medication regularly? **Yes** **No**
If Yes: _____

When was your child's last Dental Check Up? _____

Does your child have any previous surgical operations? **Yes** **No**
If Yes: _____

IN CASE OF EMERGENCY, PLEASE CONTACT: (IF YOU CANNOT BE REACHED)	
Name	
Contact No.	
Relationship to the child	

As a parent/guardian, I authorize the school attending Pediatrician/Nurse to seek appropriate treatment for my child in case of medical of medical emergency that may endanger my child's life.

This authority is granted after as reasonable effort has been made to reach me.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**