



FIRST-AID INFORMATION

(To be filled in by the parent)

Name of Student: _____ Health Card No. _____

Nationality: _____ Gender _____ Date of Birth: _____

Father's Name: _____ Mother's Name: _____

Address: _____

Area: _____ Landmark: _____

Tel. Off: _____ Resi: _____ Mobile: _____

Fax No. _____ E-mail: _____

Previous school Attended: _____ Previous Grade: _____

Please tick the appropriate boxes

Does your child have any known allergy to food or medicine? YES NO

Does your child wear glasses? YES NO

Does your child have a speech difficulty? YES NO

Does your child have a hearing difficulty? YES NO

Does your child have to take regular medicine? YES NO

Is there any medicine that your child must avoid? YES NO

(If YES, Please specify): _____

Does your child have any history of convulsions? YES NO

If yes, Please specify which anti-convulsant drug the child is on? _____

Does your child require any special care? YES NO

(If Yes, Please specify): _____

Does your child have any history of blood transfusion? YES NO

If YES, please specify the frequency of transfusion _____

Does your child have any history of hospitalisation? YES NO

If Yes please mention the reason and date of hospitalisation: _____

Is there a family history of Diabetes / Hypertension/ YES NO

Mental Disorders/Stroke/Tuberculosis/Others?

If YES, Please specify: _____

PTO

CHILD'S HISTORY OF ILLNESS (PLEASE TICK APPROPRIATELY.(IF YES, PLEASE SPECIFY MONTH/YEAR OF ILLNESS).

Infectious Diseases

Measles YES NO

Poliomyelitis YES NO

Chicken Pox YES NO

Mumps YES NO

Rubella YES NO

Whooping Cough YES NO

Diphtheria YES NO

Infective Hepatitis YES NO

Tuberculosis YES NO

Dysentery YES NO

Scarlet Fever YES NO

Non Infectious Diseases

ACCIDENTS YES NO

Allergies YES NO

Bronchial Asthma YES NO

Congenital Heart Disease YES NO

Diabetes Mellinus YES NO

Epilepsy YES NO

G6PD YES NO
(Glucose 6 - phosphate dehydrogenase deficiency)

Rheumatic fever YES NO

Surgical operation YES NO

Thalasaemia YES NO

Others if any :

Parent's Signature

_____/_____/_____
Date

TO BE FILLED BY THE OFFICE

Admission Number: _____ Date of Admission: _____

Grade: _____ Section: _____

Date: _____/_____/_____ Nurse: _____

Date: _____/_____/_____ Registrar: _____