AIT International School
MEDICAL FORM

Child's Name…….. Birth Date: ……..

Father's Name…… Mother's Name: …….

Address:……. Address:…….

…… ……

Height……. Weight…….. Blood Group: …….

Vision: ……. Hearing: ……..

Skin: …… Hair (lice):…….

Limiting Conditions: ……. ……

Physician's Signature: …….. Date: ……

(*If using AIT Medical Clinic, please call for appointment,* ***02- 524-5286***).

MEDICAL RECORD

Child's Name:…… DOB…….. Blood Group…….

Person to contact in an emergency:…… Phone:…….

Child's regular doctor: …… Phone: ……

Hospital regularly used:…… Phone: …….

(In case of an emergency, if the school can not contact the person above the child will be taken to Thammasat Hospital or the AIT Clinic)

Is the child susceptible to any of the following?:

◊ Asthma	◊ Rash	◊ Chills
◊ Fever	◊ Convulsions	◊ Headache
◊ Nose Bleeds	◊ Ear Infections	◊ Colds
◊ Throat Infections	◊ Other:……	……

Does the child have any of the following ? :

Food Allergy :……

Drug Allergy: ……

Other Allergy: ……..…

Dietary Restrictions: ……..……

Visual Problems: ……

Aural Problems: ……..….

Physical Defects: ……

Health problems that require special attention: ……..……

Any Other Relevant Information: ……..……

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Immunization Record:

Types of Diseases	**Date**		
DPT (Diphtheria/Pertussis/ Tetanus	3 injections in 1st year . ……	1st booster ……	2nd booster ……
OPV	3 injections in 1st year . ……	1st booster ……	2nd booster ……
Japanese Encephalitis	1…….	2……..	3……..
Hepatitis B	1…….	2……..	
BCG	1…….		
MMR (Measles/Mumps/Rubella)	1……..		
Other	……		

Parent's Signature:…… **Date**……