



## HARARE INTERNATIONAL SCHOOL

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### TO WHOM IT MAY CONCERN

Application has been made to enroll the following student into Harare International School:

Name: 

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First Name

Middle Name

Surname

Please complete the attached Physician's Report based on your knowledge and examination of the student. The information provided by you will be treated as confidential for the purpose of school records only.

The cost of the examination is to be borne by the parents / guardian of the child.

Thank you for your assistance.

Yours faithfully,

Vivien Brelsford  
Business Manager

## PHYSICIAN'S REPORT

**Name of Student:**     
Surname (Family Name) First Middle

Has this child had, or is currently subject to, any of the following health concerns: (tick as applicable)

<input type="checkbox"/> History of high fevers	<input type="checkbox"/> Convulsions or seizures
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Asthma
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Suspected hearing difficulties
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Wears hearing aid
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Speech problem
<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Joint injuries
<input type="checkbox"/> Other (specify) <input type="text"/>	

Has this child been vaccinated against:				Has this child had the following illnesses?			
	Yes [ ]	No [ ]	Date		Yes [ ]	No [ ]	Date
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
DPT/DT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Give details of any major operations:			Give details of any serious accidents:		
Type	Year		Head Injuries:	Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	Broken Bones:	Year	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Broken Bones:	Year	<input type="text"/>

Is this child taking medication for a long-term condition? Yes [ ] No [ ]  
 If yes, name medication and dosage:

Are there any potential side effects that the School should be aware of? Yes [ ] No [ ]  
 If yes, please give details:

Has this child ever had an allergic reaction to an insect sting / bite? Yes [ ] No [ ]  
 If yes: Date(s)  Area(s) stung:

Extensive swelling? Yes [ ] No [ ] Breathing difficulties? Yes [ ] No [ ]  
 Medication required? Yes [ ] No [ ] If yes, what medication?

Does the child carry medication to be administered in similar events? Yes [ ] No [ ]  
 If yes, details of medication and dosage:

Does this child have any other allergies or special dietary requirements? Yes [ ] No [ ]  
 If yes, give details:

Does the child have any infectious diseases that we should be aware of? Yes [ ] No [ ]  
 Give details of any other medical information that the School should be aware of:

Results of most recent eye tests:  Results of most recent hearing tests:

Date undertaken: <input type="text"/>	Date undertaken: <input type="text"/>
has this day <input type="text"/> been examined by me <input type="text"/>	Name of Student <input type="text"/> Date: <input type="text"/>  Official Stamp <input type="text"/>

Name of Physician  Address   
 Telephone Number:   
 Signature of Physician