Cowpen Road | Nassau, Bahamas
T. 242-361-5439 | E. kidz_college@outlook.com
Website. kidzcollegebahamas.com
Monday - Friday 7:00AM - 6:00PM

Student Medical Form

A. Student Information

Full Name: _____ Date of Birth: _____

Gender: _____Address: _____

City: _____

B. Parent/Guardian Information

Parent/Guardian 1 Full Name: _____Relationship to Student: _____

Phone Number: _____ Email Address: _____

Occupation: _____

Parent/Guardian 2 Full Name: _____Relationship to Student: _____

Phone Number: _____ Email Address: _____

Occupation: _____

C. Emergency Contact Information

Emergency Contact Name: Full Name: _____Relationship to Student: _____

Phone Number: _____ Email Address: _____

Occupation: _____

D. Medical Information

Doctor's Name: _____ Doctor's Phone Number: _____

Preferred Hospital: Princess Margaret Hospital _____ Doctor's Hospital _____

Health Insurance Provider: _____ Policy Number: _____

E. Physical Examination

Height: _____ Weight: _____

Temperature: _____ Blood Pressure (BP): _____

Nutritional Status: _____ Posture: _____

Scalp/Hair: _____ Skin: _____

Neck: _____ ENT (Ears, Nose, Throat): _____

Chest: _____ Abdomen: _____

Reflexes: _____ Deformities: _____

F. Vaccination Records

Please indicate if your child has received the following vaccinations and provide the date of administration:

Hepatitis B

Dose 1: _____

Dose 2: _____

Dose 3: _____

Diphtheria, Tetanus, Pertussis (DTaP)

Dose 1: _____

Dose 2: _____

Dose 3: _____

Dose 4: _____

Dose 5: _____

Haemophilus influenzae type b (Hib)

Dose 1: _____

Dose 2: _____

Dose 3: _____

Dose 4: _____

Polio (IPV)

Dose 1: _____

Dose 2: _____

Dose 3: _____

Dose 4: _____

Pneumococcal Conjugate (PCV13)

Dose 1: _____

Dose 2: _____

Dose 3: _____

Dose 4: _____

Rotavirus (RV)

Dose 1: _____

Dose 2: _____

Dose 3: _____

Measles, Mumps, Rubella (MMR)

Dose 1: _____

Dose 2: _____

Varicella (Chickenpox)

Dose 1: _____

Dose 2: _____

Hepatitis A

Dose 1: _____

Dose 2: _____

Influenza (Flu)

Annual Dose: _____

Meningococcal (MenACWY)

Dose 1: _____

Dose 2: _____

Human Papillomavirus (HPV)

Dose 1: _____

Dose 2: _____

Dose 3: _____

G. Medical History

Allergies: _____

Medications: _____

Chronic Conditions: _____

Previous Hospitalizations: _____

Surgeries: _____

Family Medical History: _____

Additional Medical Notes

H. Parental Consent

I, the undersigned, hereby authorize Kidz College to administer first aid to my child and, if necessary, seek medical treatment in the event of an emergency. I agree to inform the school of any changes in my child's health or medical information.

Parent/Guardian Name: _____ **Signature:** _____

Date: _____

Physician's Name _____ **Signature:** _____

Address: _____ **Telephone:** _____

Date: _____ **Doctor's Stamp:**

Please return this copy Kidz College Administration Office prior to or on the first offical day of school.