QUEEN'S COLLEGE HEALTH CENTRE
Village Road, P.O.Box N-7127
Nassau, Bahamas
Telephone: 242-677-7600, 393-2646, 393-2153
Fax: 242-393-3248
Email: healthcentre@qchenceforth.com

SCHOOL HEALTH FORM

Section A (To be completed by parent)

Student's Information

Student's Name: _____
First Middle Last Name

Present Grade/Phase: _____ Date of Birth of Student: _____/_____/_____ P. O. Box: _____
dd mm yy

Home Tel. Number: _____ National Insurance Number: _____

Street Address: _____

Religious Denomination of Student: _____ Nationality of Student: _____

Siblings at Queen's College:
Name: _____ Grade: _____
Name: _____ Grade: _____
Name: _____ Grade: _____

Student's Primary Care Provider: _____Tel. Number: _____

Student's Dentist: _____ Tel. Number: _____

Parent/ Guardian (1)

Name: _____

Place of Work: _____

Telephone Number at Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Parent/ Guardian (2)

Name: _____

Place of Work: _____

Telephone Number at Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Emergency Contacts
Person(s) (with tel. nos.) to contact if parents/guardians are unavailable.
(Please print name and relationship to child.)

1) _____ _____ _____
(Name) (Phone) (Relationship)

2) _____ _____ _____
(Name) (Phone) (Relationship)

_____ _____
Signature of Parent/Guardian Date

Name of Student: _____ **Grade/Phase:** _____

Student's Medical History. Please tick if your child has experienced the following:

Allergies (food, insect bites, medications)		Comments	Frequent bladder infections		Comments
Asthma/Reactive Airway Disease			Gastrointestinal or bowel problems		
Diabetes			Musculoskeletal Problems		
Seizures/Epilepsy			Speech problems		
Fainting			Vision/hearing problems		
High blood pressure/hypertension			Severe menstrual cramps		
Cancer			Attention deficit disorder/Autism		
Sickle Cell Disease			Anxiety/ panic attacks		
Behavioral/ Developmental Problems			Frequent headaches		
Seasonal Allergies			Recent Surgery or hospitalization		
Dental Problems					

Please provide, in as much detail possible, your child's medical condition/s and course of treatment (if applicable). Please note that all prescription drugs should be kept in the Health Centre and administered by the nurse with the exception of an **EPI PEN.**

_____
_____
_____

Please list all prescription medication/s or over the counter medication/s that your child takes on a regular basis:

_____
_____
_____

Medical Consent

In the event of an emergency, I_____ give consent for
(Parent/Guardian)
my child _____to be transported to Hospital/Urgent Care Facility
(Child's Name)
via ambulance.

Preferred Hospital/ Urgent Care Facility: (please tick where applicable)

☐ Princess Margaret Hospital ☐ Doctors Hospital

☐ Other_____

_____ _____ _____
Parent/ Guardian Name Signature Date

Section B - (To be completed by your child's primary healthcare provider)

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SCHOOL HEALTH FORM

Name of Student: _____ Grade/**Phase:** _____

Student's Immunization History

Vaccine	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
DTAP/ H.I.B.					
Hep. B					
Polio					
Pneumococcal					
MMR					
Varicella					
Boostrix					
HPV					
Flu					

Student Physical Exam
(must be recent within 6 months)

Date of Physical Exam: _____

Weight: (lbs.) _____ **Height**: ____ ft. ____ ins. **BP**: _____ mmHg

Pulse: _____bpm **Resp**: ____bpm

Laboratory Findings: **CBC:** ____Hb g/dl **Urinalysis:** _____

Review of Systems	Normal	Abnormal	Please elaborate on abnormal findings
Integumentary/Skin			
Neurological			
Ears, Nose & Throat			
Eyes/Vision			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Dentition			

Check here if the child wears eyeglasses ☐
Check here if the child requires a hearing aid ☐
Check here if the child has a physical handicap ☐
Please explain: _____
_____

Physician Questionnaire

Does this child have any food, insect or medication allergies? ☐ Yes ☐ No
If **YES**, please specify the triggers
_____
Is the child required to have an **EPI PEN** in his/her possession? ☐ Yes ☐ No

Does this child have asthma? ☐ Yes ☐ No
If **YES,** is a metered dose inhaler required to be used by the student? ☐ Yes ☐ No

Does this child suffer from seasonal allergies? ☐ Yes ☐ No

Is there any reason why this child should not participate in Physical Education, swimming or sports at school? If YES, please comment_____

Are immunizations up to date? ☐ Yes ☐ No

Following your physical examination, do you find this child to be in good health? ☐ Yes ☐ No
If no, please elaborate_____
_____
_____
_____

_____	_____	_____
Name of Doctor	Doctor's Signature	Date

_____
Affix Doctor's Stamp Here