



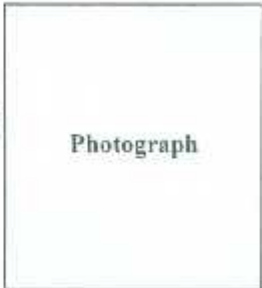
LITTLE WORLD INTERNATIONAL SCHOOL

Al Khandaq Street, Al Khobar Tel.: 887 5237 – 887 5238 Fax: 887 5238
Post Office Box 3682, Dammam 31481, Saudi Arabia

HEALTH FORM

Student's Name: _____ 1

Date of Birth: _____ (DD/MM/YY) 1



Emergency Contact:

Name: _____ 1

Emergency Tel. No.: _____ Residence: _____ 1

Mobile: _____ E mail: _____ 1

Does your child suffer from any of the following (PLEASE CHECK). If the answer is YES please provide details:

- | | | | | | | | | | |
|-----------------------|-----|--------------------------|----|--------------------------|----------------------|-----|--------------------------|----|--------------------------|
| Diabetes | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Asthma | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Epilepsy | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Convulsions | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Eyesight difficulties | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Hearing Difficulties | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

Does your child take regular medications?

- | | | | | |
|----------|-----|--------------------------|----|--------------------------|
| Diabetes | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|----------|-----|--------------------------|----|--------------------------|

Has your child ever had any of the following diseases?

- | | | | | | | | | | |
|-----------------|-----|--------------------------|----|--------------------------|------------|-----|--------------------------|----|--------------------------|
| German Measles | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Measles | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Mumps | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Meningitis | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Chicken Pox | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Hepatitis | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Glandular Fever | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | | | | |

Please indicate last inoculations administered to your child:

Polio / Tetanus / Diphtheria: _____ (DD/MM/YY)

Measles: _____ (DD/MM/YY)

German Measles: _____ (DD/MM/YY)

BCG: _____ (DD/MM/YY)

Any other information which you would like us to know about your child: