



**MEDICAL FORM**  
**For School Year 20..... / 20.....**

(please type or print)

**Identity of the Child**

Christian name ..... Name .....

Date and place of birth .....

Address.....

**Person to contact in an emergency** relationship .....

Christian name..... Name.....

**Name of Doctor** .....

Address .....

Telephone .....

<b>Blood group of the child</b> .....	<b>Weight/ height</b> .....	<b>Shoe size</b> .....
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- The child is receives homeopathic treatment? yes/ no
- The child will take medicine during his stay? yes/ no
- Which and how frequently?  
.....
- Illnesses or serious operations (which and when?)  
.....
- Has the child been vaccinated against tetanus? Yes/ no
- Date of the first injection .....
- And last top up .....

Does the child suffer from (permanently or occasionally) from (tick the boxes)

- Diabetes    insomnia    stomach aches    other....
- Asthma    contagious    disease    sunstroke
- Heart disease    sinus infection    constipation
- Epilepsy    bronchitis    diarrhea
- Skin infection    headaches    travel sickness
- Nose bleeds    nausea    insomnia

Please indicate what are the treatments used for the indicated sickness and what are the usual precautions

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- Is the child allergic? To certain medicines?

Which? .....

- Does he or she have a special diet (vegetarian,.....)? .....

- Does the child get quickly tired? Yes/no

- Is he/she susceptible to cold and draughts? Yes/no

- Are there any activities that the child can not take part in?

Which? Why? .....

- Can the child ski? Yes/no

- Can the child swim? Very well / Average / Not at all

- Does the child have any particular disability? Yes/no   remarks .....

- Date of last medical examination .....

- Have you any other remarks regarding the health of your child? .....

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**The information given is correct**

**BICS is in no way responsible for any information which is not noted in this document.**

**In an emergency** where it is impossible to contact the parents or guardian, these authorise the organiser to take every necessary medical measures (surgery, medical treatment etc.)

**Date, Name and Signature of Parent / Guardian**