



# Pupil's medical certificate

Please have the following certificate **completed and signed by your doctor and returned to the school:**  
Infirmierie du Rosey, Château du Rosey, 1180 Rolle, Switzerland.

Thank you for your cooperation. **It is very important that a correct reply be given to all sections.**

Name: \_\_\_\_\_

First name: \_\_\_\_\_

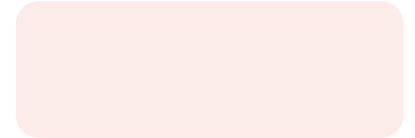
Sex  F  M Date of birth: \_\_\_\_\_ Blood group: \_\_\_\_\_

Phone number in case of emergency: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

I am the parent/guardian of the pupil named above. I give permission for the information of this form provided about my child to be reviewed and utilized by the nurses, directors and any school personnel providing school health services, for the limited purpose of meeting my child's health and educational needs.

Place and date: \_\_\_\_\_ Signature (parent or guardian):



Would you like to discuss any aspect of your child's health with a school nurse?  YES  NO

## SECTION I - PUPIL'S MEDICAL HISTORY

Has he/she, or does he/she suffer (ed) from:

- |  |  |   |  |
|--|--|---|--|
| • Any concerns about nutrition, eating habits, weight etc. | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Diabetes (if yes, state type)                         | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any trouble with sleeping habits                         | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____   |  |
| • Any allergies (food, insects, medication etc.)           | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any orthopedic trouble                                | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any social, emotional or behavioral problem              | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Epilepsy  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any problem with vision, hearing or speech               | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any heart trouble (heart murmur etc.)                 | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any significant accidents or injuries                    | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any recurrent illnesses (tonsillitis, headaches etc.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any lung problems/asthma                                 | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any skin problems                                     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any concerns about kidneys or uro-genital system         | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Others  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any learning differences (e.g. dyslexia or other)        | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____   |  |

**Please explain any "Yes" answers from above.** (Nature and frequency of the trouble, last episode, intensity etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION II - PAST ILLNESSES** Check the correct response, and give date if possible:

	DATE		DATE		DATE			
• Mumps	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• German measles	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
• Scarlet fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Whooping cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	(mononucleosis, tuberculosis, typhoid, malaria, Pfeiffer etc.)		
• Chickenpox	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Diphtheria	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____	_____	_____
• Measles	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____	_____	_____

**SECTION III - GENERAL ISSUES**

Has the student ever spent time in hospital or undergone surgery? If so, give details.

YES  NO \_\_\_\_\_

\_\_\_\_\_

Does the student take medication regularly or occasionally? If so, which and for what reason?

YES  NO \_\_\_\_\_

\_\_\_\_\_

Is there any reason that the pupil may not participate fully in school activities, including physical education? If yes, give the reason, and the necessary restriction/adaptation:

YES  NO \_\_\_\_\_

\_\_\_\_\_

Does your child follow/has your child followed any psychological or psychiatric treatment? If so, please give details:

YES  NO \_\_\_\_\_

\_\_\_\_\_

Date(s) of last eye test: \_\_\_\_\_ Date(s) of last dental check-up: \_\_\_\_\_

**SECTION IV - VACCINATIONS** Please check the correct response and give date if possible:

	DATE		DATE		DATE				
• Hepatitis A + B Twinrix	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Tetanus	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Booster	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	
• Hepatitis A	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Poliomyelitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Type of vaccine	_____	_____	
• Hepatitis B	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Diphtheria- Tetanus-Whooping cough (Di-Te-Per)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____	_____	_____	
• Tuberculosis BCG	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Diphtheria- Tetanus-Polio (Di-Te-Pol)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____	_____	_____	
• Tuberculin test (Mantoux)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	• Other vaccinations	_____	_____	Type of vaccine	_____	_____	
	<input type="checkbox"/> successful <input type="checkbox"/> unsuccessful		• Measles- Mumps-Rubella (MMR)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	First vaccine	_____	Second vaccine	_____

**OBLIGATORY: PLEASE ATTACH A COPY OF YOUR CHILD'S VACCINATION RECORD IN ENGLISH**

Miss / Mr. \_\_\_\_\_

- is in good health.
- has not been in recent contact with anyone suffering from a contagious disease.
- should be under observation for the following:

\_\_\_\_\_

\_\_\_\_\_

Place and date: \_\_\_\_\_ **Doctor's stamp and signature:**

