



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: _____

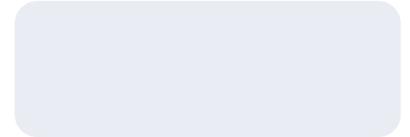
Sex F M Date of birth: _____ Blood group: _____

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"/> NO <input type="checkbox"/> YES	_____	• Tetanus	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____	Booster:	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____
• Hepatitis A	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____	• Poliomyelitis	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____	Type of vaccine	_____	
• Hepatitis B	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____	• Diphtheria-Tetanus-Whooping cough (Di-Te-Per)	<input type="checkbox"/> NO <input type="checkbox"/> YES	Date	_____		
• Tuberculosis BCG	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____	• Diphtheria-Tetanus-Polio (Di-Te-Pol)	<input type="checkbox"/> NO <input type="checkbox"/> YES	Date	_____		
• Tuberculin test (Mantoux)	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____	<input type="checkbox"/> successful <input type="checkbox"/> unsuccessful					
• Measles-Mumps-Rubella (MMR)	<input type="checkbox"/> NO <input type="checkbox"/> YES	First vaccine _____	Second vaccine _____					
• Other vaccinations	_____	Type of vaccine	_____					
• COVID-19	<input type="checkbox"/> NO <input type="checkbox"/> YES	Date last vaccine _____	Name of vaccine _____	or	<input type="checkbox"/> RECOVERED from COVID-19	Date	_____	

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 _____ Date _____

Doctor's stamp and signature