Pupil's medical certificate

Please have the following certificate **completed and signed by your doctor and returned to the school:** Infirmerie 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. ☐ YES ☐ NO
- Any trouble with sleeping habits ☐ YES ☐ NO
- Any allergies (food, insects, medication, etc.) ☐ YES ☐ NO
- Any social, emotional or behavioral problem ☐ YES ☐ NO
- Any problem with vision, hearing or speech ☐ YES ☐ NO
- Any significant accidents or injuries ☐ YES ☐ NO
- Any lung problems/asthma ☐ YES ☐ NO
- Any concerns about kidneys or uro-genital system ☐ YES ☐ NO
- Any learning differences (e.g. dyslexia or other) ☐ YES ☐ NO

_____

- Diabetes (if yes, state type) ☐ YES ☐ NO

_____

- Any orthopedic trouble ☐ YES ☐ NO
- Epilepsy ☐ YES ☐ NO
- Any heart trouble (heart murmur, etc.) ☐ YES ☐ NO
- Any recurrent illnesses (tonsillitis, headaches, etc.) ☐ YES ☐ NO
- Any skin problems ☐ YES ☐ NO
- Others ☐ YES ☐ 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	☐ YES ☐ NO	_____	• German measles	☐ YES ☐ NO	_____	• Other (mononucleosis, tuberculosis, typhoid, malaria, Pfeiffer etc.)	☐ YES ☐ NO
• Scarlet fever	☐ YES ☐ NO	_____	• Whooping cough	☐ YES ☐ NO	_____	_____	_____
• Chickenpox	☐ YES ☐ NO	_____	• Diphtheria	☐ YES ☐ NO	_____	_____	_____
• Measles	☐ YES ☐ NO	_____	• Pneumonia	☐ YES ☐ 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 you 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	☐NO ☐YES	_____	• Tetanus	☐NO ☐YES	_____	Booster: ☐NO ☐YES	_____
• Hepatitis A	☐NO ☐YES	_____	• Poliomyelitis	☐NO ☐YES	_____	Type of vaccine	_____
• Hepatitis B	☐NO ☐YES	_____	• Diphtheria-Tetanus-Whooping cough (Di-Te-Per)	☐NO ☐YES	Date	_____	
• Tuberculosis BCG	☐NO ☐YES	_____	• Diphtheria-Tetanus-Polio (Di-Te-Pol)	☐NO ☐YES	Date	_____	
• Tuberculine test (Mantoux)	☐NO ☐YES	_____	☐ successful ☐ unsuccessful				

• Measles-Mumps-Rubella (MMR) ☐NO ☐YES First vaccine _____ Second vaccine _____

• Other vaccinations _____ Type of vaccine _____

• **COVID-19** ☐NO ☐YES Date last vaccine _____ Name of vaccine _____ or ☐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