Roztocká 9, Sedlec, 160 00 Praha 6, Czech Republic
Early Years T 245 005 095
Primary School T 224 325 183 F 224 325 765
Junior High School T 224 315 336 F 224 325 765
Senior High School T 245 005 045
www.riversideschool.cz

MEDICAL FORM

Student's Surname:				**First Name:**			
Date of Birth:	**Day**		**Month**		**Year**		Male
Date of Admission:	Month			Year:			
Insurance company:							*Please, provide a copy of your child´s health insurance card (front and back of card).*

Does your child have any allergies including food, medicines or any other substance?

Does your child have any special dietary requirements?

Is your child currently taking any medication on a regular basis?
If yes please explain including name of medication, dosage, route of administration, and rationale for administration.

Does your child need to wear any of the following?

Glasses ☐	Contact lenses ☐	Hearing aids ☐	Braces ☐	Other ☐

Please describe:

Does your child have any restrictions to taking full part in school activities?

Has your child had any of the following illnesses?
Please tick√ and/or give explanations as appropriate, if child has had any of the following illnesses/conditions:

Chicken Pox ☐	Diabetes ☐	Tuberculosis ☐	Asthma ☐
Whooping Cough ☐	Epilepsy ☐	Pneumonia ☐	Anaemia ☐
Rheumatic Fever ☐	Heart Condition ☐	Frequent Ear Infections ☐	Polio ☐
Scarlet Fever ☐	Fainting ☐	Frequent Colds ☐	Serious Injury * ☐
Hearing Difficulty ☐	Vision Impairment ☐	Surgery* ☐	Other * ☐

* Please describe below:

AUTHORISATION FOR MEDICATION AT SCHOOL AND ON SCHOOL TRIPS			
I give permission for the school nurse / staff to treat my child with over-the-counter medications if needed.			
	Yes	No	Contact parent / guardian first
	☐	☐	☐

MEDICAL RELEASE AND PERMISSION TO TREAT

In case of injury or emergency, the appointed persons at Riverside School have permission to administer first aid and if necessary to send my child to a Prague hospital for emergency treatment.

V případě zranění nebo jiného nenadálého zdravotního problému dáváme zplnomocnění zástupcům školy Riverside School zprostředkovat první pomoc našemu dítěti anebo zajistit záchranou službu/ převoz do nemocnice.

Mother's Name :_____ Signature: _____

Father's Name :_____ Signature: _____

Date: _____

Please remember to inform the school nurse / class teacher if your child is prescribed medication for a short term during the year eg. antibiotics.

Please make sure you provide a copy of your child's medical insurance card.

Please attach filled in Immunization Record form.

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IMMUNIZATION RECORD

To be attached to the Medical Form

Student's Surname:		**First Name:**	

Please complete the following record including the dates (dd/mm/yy) vaccines were given

	IMMUNIZATION	1st	2nd	3rd	4th	5th	Booster
	Diphtheria / pertussis / tetanus / DPT or DTaP						
	Polio / OPV or IPV						
	BCG (tuberculosis)						
	MMR (measles-mumps-rubella combo)						
	Varivax						
	Td (tetanus booster in last 10 yrs)						
	Hib						
	Meningitis C						
	Hepatitis A						
	Hepatitis B						
	FSME or TBE (tick-borne encephalitis)						
	HPV (12-13 year old girls)						
	Rotavirus vaccine						
	PCV (pneumococcal)						
	Tuberculin skin test (PPD or Tine)	Date	Result	Date	Result	Date	Result
	(record result)						
	OTHER:						

Hib - protects against major illnesses like blood poisoning, pneumonia and meningitis

Men C - given to babies, 3 doses (2, 3 and 4months)
- children and young people 1–25 years not vaccinated should have one single vaccine

Hepatitis A / B and tick borne encephelitis vaccines are strongly recommended

TB skin test - it is currently recommended that the test is repeated every 3years if the child has not had the vaccine.
- if the vaccination date is more than 10years ago a TB skin test is recommended.

We have voluntarily witheld the following immunizations for personal or religious reasons:

Parents' comments:	