École Française Internationale
FRENCH INTERNATIONAL SCHOOL | សាលាអន្តរជាតិបារាំង

HEALTH QUESTIONNAIRE

Student Information		
FAMILY NAME	First Name	Preferred Name
Date of birth (DD/MM/YYYY)	Age	Female ☐ Male ☐
contact in case of emergency 1. 2. 3.	In case of emergency, preferred hospital	

Medical History

1.Please describe any medical conditions and health history that your child may have that EFI should be aware of i.e epilepsy, diabetes, asthma, surgery, others.

2. Does your child take any form of medication on a regular basis?
Yes ☐ No ☐ If yes, please provide full details.

Note: If you wish to have medication administered to your child at school, arrangements must be made in advance and a signed note from the parent and the doctor's prescription must be provided.

3. Does your child have any difficulty with their vision? Yes ☐ No ☐ If yes, please provide details.

Does your child's vision have been checked recently? Yes ☐ No ☐

5. Does your child have any earing problems ? Yes ☐ No ☐ If yes, please provide details.

6. Does your child have any allergies? If yes, please provide details. In case of dietary restriction , please provide full details.

7. Has your child visited the dentist in the last year? Yes ☐ No ☐
If yes, please provide details.

8. Any other concern about your child?

Please provide a copy of your child's immunization record.

Date(/MM/AAAA) Parent(s) name(s) and signature(s)