Brillantmont
International School Lausanne

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nurse@brillantmont.ch
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SCHOOL MEDICAL FORM

Name of student : .....

Date of birth : ..... Nationality : .....

Parents home address : .....
.....
.....
.....
.....

Emergency tel. number: ..... Fax number : .....

Email address : .....

Name, address and relationship of contact person in case of health related problem, if different from the above: .....
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For Parents

1. Please complete the details at the top of this page.
2. The Doctor's Medical Certificate must be completed by your child's Medical Doctor.
3. Please ask the Doctor to sign the form, and return it directly to the School Nurse.
4. Please ensure your child's vaccinations are up-to-date – see page 3; vaccinations required are marked with an asterisk (*).
5. MEDICINE – for the safety and wellbeing of your child, please do not send any medicine to school, except those detailed on this form.
6. Please contact the School Nurse if you have any queries or concerns : e-mail : nurse@brillantmont.ch

Doctor's Medical

To be completed by a Medical Doctor. This form will be given to the School's Doctor.

Name of student : .....

Date of birth : ..... Nationality : .....

All students require a current medical examination.

Previous History (tick box), if yes please specify:

a. Contagious diseases: no ☐ yes ☐
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b. Allergic diseases: no ☐ yes ☐
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c. Metabolic diseases: no ☐ yes ☐
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d. Cardiovascular diseases: no ☐ yes ☐
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e. Diseases of the nervous system: no ☐ yes ☐
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f. Diseases of the digestive system: no ☐ yes ☐
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g. Diseases of the respiratory tract: no ☐ yes ☐
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h. Haematological diseases: no ☐ yes ☐
.....

i. Diseases of the muscles/bones: no ☐ yes ☐
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j. Other diseases: no ☐ yes ☐
.....

k. Surgery: no ☐ yes ☐
.....

l. Accidents: no ☐ yes ☐
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Current health condition: Please detail any current physical or psychological diseases or illness requiring treatment or counselling and provide a detailed medical report in English.

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Current medication

Name of medicine	Dose	Amount	Frequency

Please complete the vaccination record below :

VACCINE	DATE					
Diphtheria*						
Tetanus*						
Polio*						
MMR*						
Hepatitis B**						
Varicella ***						
HPV** 11-14 year old girls						
Meningococcal C						
Other						

* Required vaccinations for school admission
** Recommended vaccinations
*** Has the child had chicken pox? If no, consider vaccination

Doctor's signature

Name: .....

Signature: .....

Date: .....

Contact details
(e-mail/telephone/fax) : .....

For Nurse use only

Student Name: .....

Date: .....

Weight: ☐ Height: ☐ BMI for age: ☐

Does the student have any medicine with him/her (give details) ?

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How will the medicine be managed ?

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Concerns:

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