WINDSOR
SCHOOL

MEDICAL EXAMINATION FORM

PLEASE HAVE LEARNER'S PHYSICIAN COMPLETE

Date of Last Examination: _____
DD/MM/YY

_____
LAST NAME *FIRST NAME* *MIDDLE NAME* *BIRTHDAY DD/MM/YY*

Year/Grade: _____ Age: _____ Height: _____ BP: _____

Significant Past Illness or Injuries: _____
_____

Allergies: _____

History of Pulmonary or Cardiac Problems: _____

HEENT: _____ Lungs: _____

Cardiovascular: _____ Murmurs: _____

Heart Rate: *Before Exercise* _____ *After Exercise* _____

Musculoskeletal: _____

LABORATORY
Urinalysis: _____ Hematocrit or Hemoglobin: _____

Liver: _____ Spleen: _____ Hernia: _____

Dental Status
Braces: _____ Yes _____ No False Teeth: _____ Yes _____ No

General Comments or Recommendations: _____
_____
_____

Completed Immunisations Polio (Date) _____ Tetanus (Date) _____
DD/MM/YY *DD/MM/YY*

I have examined the named learner and find him/her physically fit for all school related activities.

_____ (____) _____
PHYSICIAN *PHONE*

_____ _____
ADDRESS *DATE DD/MM/YY*

PHYSICIAN STAMP

WINDSOR
SCHOOL

IMMUNISATION HISTORY

LEARNER NAME

DATE OF BIRTH DD/MM/YY

MCI/CHART #

DATES OF IMMUNISATION					
Hep-B					
IPV • OPV					
DTaP • DT					
Td					
Hib					
MMR					
Varicella					
PCV					
Rotavirus					
Hep-A					
HPV					
MCV4					

MEDICAL EXEMPTION: This child is exempt from receiving each of the vaccines listed below for a MEDICAL REASON [must be approved by a licensed physician (MD or DO) or his/her authorised representative (e.g. PA or APRN)]

LIST VACCINE(S)	DATE TEMPORARY EXEMPTION EXPIRES	PERMANENT EXEMPTION (Check if applicable)

PHYSICIAN NAME

PHYSICIAN ADDRESS

PHYSICIAN PHONE

PHYSICIAN SIGNATURE

DATE DD/MM/YY

PHYSICIAN STAMP

WINDSOR
SCHOOL

MEDICAL INFORMATION AND CONSENT FORM

Learner Full Name: _____ Sex: _____ M _____ F

Date of Birth: _____ Parent/Guardian: _____

Address: _____

City: _____ State/Province: _____ Postal Code: _____

Country: _____ Phone (____) _____ (____)_____
HOME CELL

1. The learner's health condition: _____ Excellent _____ Good _____ Fair _____ Poor

2. Does the learner have any allergies or require special medical treatment? If 'yes' please explain.

_____

_____

3. Please list any physical disorders which may interfere with your child's active participation in the Windsor School program: _____

_____

_____

4. Has the learner suffered mental disorders requiring psychiatric treatment? _____ Yes _____ No

If yes, please explain: _____

_____

5. Please indicate the medication which you permit the Residential Instructor to administer:

_____ Aspirin _____ Non-aspirin pain reliever Other: _____
PLEASE SPECIFY

6. Has the learner ever had Chicken Pox (Varicella)?

_____ Yes, on this date _____ _____ No
DD/MM/YY

I authorise Windsor School staff to arrange appropriate medical treatment for my child and to authorise medical personnel to administer such treatment if deemed necessary.

_____

PARENT SIGNATURE DD/MM/YY

WINDSOR
SCHOOL

Fall 2018 - Health Insurance Form	Due by: August 28th 2018
Learner's First Name _____ Parent's Email address	Last Name (_____)_____ Phone Number
Please include a photocopy of the front and back of your insurance card when submitting this form.	
Name of Private Insurance Company: _____ Address: _____ Policy Holder: _____ Relation to Policy Holder: _____ Coverage Period:_____ Policy # _____ Group # _____ Phone #_____	
By submitting this form I acknowledge that my health insurance is valid in Nassau, The Bahamas for the time my child will be enrolled at Windsor Preparatory School (WPS). I am responsible for any medical expense incurred during my child's enrolment at WPS and WPS will not be responsible for any accident or sickness medical expense.	
_____ Signature of Parent/Guardian	_____ Date