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MEMBER OF THE FEDERATION OF BRITISH
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MEDICAL DECLARATION FORM

1 STUDENT & FAMILY INFORMATION

Student Surname _____ Student First Name _____

Date of Birth _____ Nationality _____ Passport No _____

Parent Contact Information Student lives with: Both Parents Father Mother Guardians

Father's Name _____ Mother's Name _____

Home Telephone _____ Home Telephone _____

Mobile Telephone _____ Mobile Telephone _____

2 FOR EMERGENCY (IF PARENTS CANNOT BE REACHED)

Contact Name _____ Relationship _____

Home Telephone _____ Mobile Telephone _____

Doctor's Name _____ Doctor's Telephone _____

3 STUDENT MEDICAL HISTORY

(a) Has your child been diagnosed with any of the following?

Chicken pox	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	Poliomyelitis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Hepatitis A,B or C	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Febrile Convulsion	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Chronic ear infection	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>	Eczema	<input type="checkbox"/>				

If yes please give details _____

(b) Has your child ever had surgery / hospitalization in the past? Yes No

If yes please give details _____

(c) Any known allergies (eg Elastoplasts, Iodine, Penicillin)? Yes No

If yes please give details _____

(d) Medication taken on a regular basis _____

(e) Any other relevant information regarding your child's medical history?

4 IMMUNISATION RECORDS

Measles/Mumps/Rubella (MMR)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Diphtheria/Pertussis/Tetanus (DPT)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Poliomyelitis (OPV / IPV)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Diphtheria/Tetanus (DT)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Hepatitis A	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Meningitis A & C	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____

Additional Vaccinations & dates received:

Vaccinations _____ Date: _____

Vaccinations _____ Date: _____

Vaccinations _____ Date: _____

Vaccinations _____ Date: _____

5 EMERGENCY CARE PERMISSION

Permission is hereby given for emergency measures to be taken in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

I certify that all information given on this form is complete and correct.

I acknowledge that it is my responsibility to inform KIS medical department of any changes in my child's health, physical condition or medical needs.

SIGNATURE OF PARENT / GUARDIAN

DATE

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
day	month	year	

Name in Print: _____