



**CONFIDENTIAL**

**INFORMATION TO THE HEALTH CARE FROM PARENTS TO A NEW PUPIL**

For your child's safety, fill in this form as precisely as possible. Leave the completed form in a sealed envelope to the schoolnurse.

Surname, first name		Personal number(dob)
Address	Area code	Phone number
The mothers name (or guardian)	Profession	Personal number
Address (if other than the pupil)	Home phone number	Phone number at work
The fathers name (or guardian)	Profession	Personal number
Address (if other than the pupil)	Home phone number	Phone number at work
Pre-school/Day care		Phone number

**Brothers or sisters**

Date of birth	Name	Date of birth	Name

Country in which the pupil is born (if not Sweden)	Year of arrival to Sweden:
The country where the parents where born (if not Sweden)	
The father:	The mother:

**Have your child been in school in Sweden before?**                      Yes                       No

**If yes, what school?**

The schools name	Town

Does any of following affection/complaint exist in the family?	If yes with who?	If yes with who?
Allergy                      No <input type="checkbox"/> Yes <input type="checkbox"/>		
Serious disease                      No <input type="checkbox"/> Yes <input type="checkbox"/>		
Hearing impairment                      No <input type="checkbox"/> Yes <input type="checkbox"/>		



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**Does your child have:**

Asthma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Hay-fever	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Hearing impairment	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Eczema	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Visual impairment	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Other allergies	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Cramp illness	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Mothers height: \_\_\_\_\_

Fathers height: \_\_\_\_\_

Does your child take any kind of medicine?

Does your child have a special diet concerning allergy ? Yes  No

If yes, what:

**For your child's safety, we need a doctors certificate on the special diet!**

**Which vaccinations has your child got and when?**

	Date	Date	Date	Date	Date
Polio					
Diphtheria/Tetanus					
MMR (measles, mumps, rubella)					
BCG					
Others					

Anything else about your child that you are concerned about, or wish to inform the school health?

**Date**

**Parents/Guardians signature**

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