

**Stonehill International School**

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An Embassy Group Education Initiative



**STONEHILL**  
INTERNATIONAL SCHOOL

## STUDENT HEALTH QUESTIONNAIRE

To be completed by the parents or guardians. Please return the 'Confidential Medical Record & Emergency Card' & the 'Student Health Questionnaire' to the admission Office.

Family name ..... First name .....

Date of birth (DD/MM/YYYY) ..... Sex M  F

Medical History	Yes	No	If yes, explain
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	.....
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	.....
Cardiac disorder	<input type="checkbox"/>	<input type="checkbox"/>	.....
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Gastrointestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>	.....
Hearing disorder	<input type="checkbox"/>	<input type="checkbox"/>	.....
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	.....
Neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>	.....
Orthopaedic condition	<input type="checkbox"/>	<input type="checkbox"/>	.....
Respiratory illness	<input type="checkbox"/>	<input type="checkbox"/>	.....
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	.....
Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	.....
Visual disorder	<input type="checkbox"/>	<input type="checkbox"/>	.....
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	.....

Participation for Sports Questionnaire	Yes	No	If yes, explain
Is the student			
presently taking medication?	<input type="checkbox"/>	<input type="checkbox"/>	.....
diagnosed with asthma?	<input type="checkbox"/>	<input type="checkbox"/>	.....
prescribed asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Does the student			
wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	.....
have any known deformities?	<input type="checkbox"/>	<input type="checkbox"/>	.....
tire quickly during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	.....
have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	.....

	Yes	No	If yes, explain
Has the student			
ever fainted during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever had racing of their heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever been told they had a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever been knocked out or become unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever lost their memory?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	.....
ever had numbness or tingling in their arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	.....
 Has any member of your family died before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Has anyone in your family had a heart attack before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	.....

I certify that the above information is correct to the best of my knowledge.

Signature of Parent or Guardian

Date