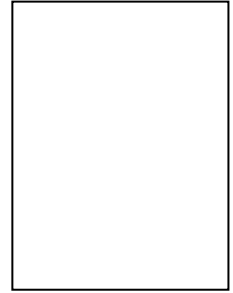


To be added to the application form in a closed envelope addressed to the nurse

European School Luxembourg I
23, Boulevard Konrad Adenauer
L – 1115 LUXEMBOURG

European School Luxembourg II
6 Rue Gaston Thorn
L – 8268 BERTRANGE



SCHOOL MEDICAL SERVICE

**CONFIDENTIAL QUESTIONNAIRE
TO COMPLETE AND RETURN
TOGETHER WITH A COPY OF THE VACCINATION CARD**

PERSONAL INFORMATION

NAME of child: FIRST NAME:

DATE of birth: PLACE of birth:

NATIONALITY: SEX: Masc. Fem.

Cycle: Class: Language section

ADDRESS:

NAME of parent or guardian:

ADDRESS:

NAME of current doctor:

CONTACT DETAILS

Tel Mother: Private: Office :

Mobile : :

Tel. Father: Private: Office :

Mobile :

Contact details of another person who has your permission to collect your child in case we are unable to reach you.

NAME:

Tel : Private : Office:

Mobile:

FAMILY HISTORY

FATHER

Name:First name.....

Date of birth:Place of birth:

Profession:State of health:

Height : (cm) :

MOTHER

Name:First name.....

Date of birth:Place of birth:

Profession:State of health:

Height : (cm) :

Siblings

Names	Place and date of birth	State of health

PREVIOUS MEDICAL HISTORY

Circumstances surrounding the birth and development

Was the child born at term? Yes/No
Before term ? Yes/No
After term? Yes/No
Did the child have to be resuscitated? Yes/No
Were there any breathing, digestive or any other difficulties? Yes/No
Were there any malformations at birth ? Yes/No

Comments if yes.....

WEIGHT at birth.....LENGTH at birth.....

Did your child walk unaided by the age of 18 months? Yes/No
Does your child have any of the following problems?:
A developmental delay? Yes/No
Hyperactivity ? Yes/No
Psychological or behavioural problems ? Yes/No
Any syndrome ? Yes/No
Other problems other than those listed above? Yes/No

.....

Infectious Illnesses

Has your child suffered from any of the following illnesses? If yes, please indicate the date:

Measles: Viral or bacterial Meningitis:

Rubella: Viral Hepatitis:

Chickenpox: Bronchopneumonia:

CURRENT TREATMENT

Is your child currently taking any medication? Yes/No
 If yes, please specify which.....

Is he/she receiving physiotherapy ? Yes/No
 Has your child had an ophthalmic examination ? (Vision test) Yes/No
 Does he/she wear glasses? Yes/No regularly? Yes/No
occasionally? Yes/No
 Date of the last vision test?

Do you feel that your child hears normally? Yes/No
 Is his/her hearing being monitored? Yes/No

Has he /she ever been referred to a:psychologist? Yes/No
speech therapist? Yes/No
 Has your child benefited from a Learning Support service either in or out of the classroom? Yes/No
 Has your child benefited from a specially adapted Individual Educational Programme? Yes/No
 Comments, if yes

All this information is confidential and cannot be transferred. If the child leaves the school, the parents may recover the form from the Medical Service.

In case of fever and/or pain, I hereby request and authorize the school nurse to administer:

Paracetamol *Yes/No*

Ibuprofen *Yes/No*

If your child suffers from a chronic disease or from an illness that requires special attention, please do not forget to inform the teacher and give him/her the necessary instructions as soon as possible.

In case of a serious accident whilst your child is at school, he/she will be taken to the hospital by ambulance, accompanied by the professionals of the emergency services. You will be immediately contacted by the school.

The Medical Service remains at your disposal, of course.

Date:..... Parents' signatures:.....

.....

NURSES		
European School Luxembourg I 23, Boulevard Konrad Adenauer L – 1115 Luxembourg	Nursery	Mrs. Claudine REUTER
	Primary	Mrs. Nadine FAYOLLE Mrs. Larissa MOLITOR
	Secondary	Mrs. Silvia GARCIA Mrs. Nadine FAYOLLE
European School Luxembourg II 6 Rue Gaston Thorn L – 8268 Bertrange	Nursery/Primary	Mrs. Margarita RODRIGUEZ Mrs. Marjorie THIRY
	Secondary	Mrs. Alexandra ROTH Mrs. Marjorie THIRY