



Beau Soleil  
Collège Alpin International

# Medical Form



## Student information

First name Last name

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>>

Date of birth Gender

>>

female  male

Place of birth Nationality

>>

>>

Confession Blood type

### Previous doctor details

First name Last name

>>

>>

Address

>>

Telephone number Email address

>>

>>

## Vaccinations

This section should be completed by the parents or guardian of the applicant.

- We do authorise the school nurses to complete the vaccinations of our child.
- We do not authorise the school nurses to complete the vaccinations of our child.

Please provide a vaccinations' report copy (compulsory).

Students participating to a school trip will automatically be vaccinated by the school medical centre or by the vaccination service of the "CHUV medical centre" in Lausanne.

## Your child's health

It is important that each student plays a full and active part in the School's programme, following the long established ethos of Collège Beau Soleil. Having a clear understanding of their medical history is a key part in the school supporting each student to fulfil their school commitments. Our pupils' health is an essential element for their success at Beau Soleil. Our health centre provides your child with physical and psychological help. The school health centre is comprised of a team of multi-disciplinary health professionals dedicated to the well-being of students in the school. The school doctor will decide the appropriateness of any student's health and abilities to play an active role in all school activities. Students are forbidden to keep medicines in their rooms unless the Health Centre team have given their permission, which will be done on an individual basis. On arrival, any prescribed medication must be given to the health centre for inspection together with a copy of the prescription. If this is not received, the school reserves the right to dispose of the medication. Any homeopathic medicines

must be approved by the school doctor before agreement can be given for students to be treated with these. Any supplements must be approved by the school doctor in conjunction with written confirmation from originating nutritionists and recognised medical professionals. If parents wish for a student not to be treated with conventional medication, please complete the separate consent form, which is available on request. The confidentiality and rights of boarders as patients are appropriately respected. This includes the right of a boarder to be "Gillick Competent" to give or withhold consent for his/her own treatment. (Gillick Competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. A child will be Gillick competent if he or she has sufficient understanding and intelligence to understand fully what is proposed). (National Minimum Standard 2015)

## Signature

By his/her signature, the parent or guardian certifies that the information given in this form is correct. Collège Beau Soleil can under no circumstances be held responsible for any problem which could occur and has not been mentioned in this form.

I, hereby [name] ..... authorise Collège Alpin Beau Soleil in the event of an emergency, to take the measures necessary for the health of our child (hospitalisation - medical or psychiatric, operation, etc.)

First name	Last name
>>	>>
Place	Date
>>	>>
Signature	
>>	

## Additional comments

## Medical certificate to be completed by a doctor

Weight	Height
>>	>>
kg	cm
Blood pressure	Blood type
>>	>>
Childhood illnesses	
<input type="checkbox"/> measles	<input type="checkbox"/> chicken pox
<input type="checkbox"/> german measles	<input type="checkbox"/> mononucleosis
<input type="checkbox"/> scarlet fever	<input type="checkbox"/> mumps
Prior hospitalisation(s)	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Prior accident(s)	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Current medication	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Psychological/logopaedic therapy	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Dental health (medical status and supervision)	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Visual perception	
wears glasses	<input type="checkbox"/> yes <input type="checkbox"/> no
wears contact lenses	<input type="checkbox"/> yes <input type="checkbox"/> no
Other illnesses	
Respiratory and digestive	
<input type="checkbox"/> frequent tonsillitis	<input type="checkbox"/> bronchitis
<input type="checkbox"/> frequent otitis	<input type="checkbox"/> asthma
Gastric, digestive or intestinal disorder	
<input type="checkbox"/> recurrent diarrhea	
<input type="checkbox"/> constipation	
Heart and blood	
<input type="checkbox"/> heart murmurs (congenital or developed)	<input type="checkbox"/> coagulation disorders
<input type="checkbox"/> circulatory disorders	<input type="checkbox"/> frequent hematoma(s)
<input type="checkbox"/> anaemia	
Neurological and endocrinological	
<input type="checkbox"/> fits (non-diagnosed)	<input type="checkbox"/> hyperventilation
<input type="checkbox"/> epilepsy	<input type="checkbox"/> diabetes
Orthopedic / skeletal	
<input type="checkbox"/> trauma to joints requiring treatment	
<input type="checkbox"/> fractures	
<input type="checkbox"/> rheumatoid arthritis	
Metabolism and dermatological	
<input type="checkbox"/> obesity	<input type="checkbox"/> psoriasis
<input type="checkbox"/> food disorder(s) (bulimia, anorexia)	<input type="checkbox"/> urticaria
<input type="checkbox"/> eczema	<input type="checkbox"/> acne (please provide details of treatment)
Urinary and gynaecology	
<input type="checkbox"/> kidney disease	<input type="checkbox"/> dysmenorrhea
<input type="checkbox"/> frequent cystitis	<input type="checkbox"/> irregular periods
<input type="checkbox"/> bedwetting	<input type="checkbox"/> other disorder(s)
Allergy	
<input type="checkbox"/> medication(s)	<input type="checkbox"/> hay fever
<input type="checkbox"/> food	<input type="checkbox"/> other(s)

If you tick any option on this page, please provide all information (dates, treatment, copy of medical reports, prescriptions, etc.). Documents must be in French or English only.

Limitation of physical activity

Has the student any physical limitations?

yes (please complete details below)

no

Limitations due to:

illness

injury

The student cannot practice sports until:

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (maximum 3 months before revaluation)

The student may practice, within the limits of its possibilities, the following activities:

football

basketball

volleyball

cricket

tennis

swimming

badminton

biking

football

fitness

climbing

walking

running

trekking

rugby

combat sports

ski, snowboard

others

Treatment(s), comment(s)

By his / her signature, the doctor certifies that the information stated in this form is correct. Collège Beau Soleil can, under no circumstances, be held responsible for any problem which could occur and has not been mentioned.

Doctor's first name

Doctor's last name

>>

>>

Place

>>

Stamp and signature

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