Brillantmont
International School Lausanne

Avenue Charles-Secrétan 16
1005 Lausanne / Switzerland
Tel: +41 21 310 04 00
nurse@brillantmont.ch
www.brillantmont.ch

SCHOOL YEAR MEDICAL FORM

Parents / Guardians

1. Please complete the details on this page.
2. The Doctor's Medical Certificate must be completed by your child's Medical Doctor.
3. Please ask the Doctor to sign the form and return it directly to the School Nurse.
4. Please ensure your child's vaccinations are up-to-date – see page 3
   Required vaccinations are marked with an asterisk (*).
5. MEDICINE – for the safety and wellbeing of your child, please do not send any medicine to school, except those detailed on this form.
6. Please contact the School Nurse if you have any questions or concerns by e-mail : nurse@brillantmont.ch

Name of student :.....

Date of birth : ..... Nationality : .....

Parents home address : .....

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Emergency tel. number: .....

Email address : .....

Name, address and relationship of contact person in case of health related problem, if different from the above:.....

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Basic Health Questions:

1-Does your child have any allergies?

- Food allergies no ☐ yes ☐
- Environmental/seasonal allergies no ☐ yes ☐
- Medication allergies no ☐ yes ☐

If you have answered yes above, please specify what your child is allergic to:

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2-Does your child require a special diet for medical, religious, or cultural reasons? no ☐ yes ☐
If you have answered yes above, please specify:

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3- Does your child know how to swim? no ☐ yes ☐ Level? beginner ☐ intermediate ☐ advanced ☐

4- Can your child fully participate in sports activities? no ☐ yes ☐ If you have answered no, please specify:

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Doctor's Medical

To be completed by a Medical Doctor. This form will be given to the School's Doctor.

Name of student : .....

Date of birth : ..... Nationality : .....

All students require a current medical examination.

Previous History (tick box), if yes please specify:

a. Contagious diseases: no ☐ yes ☐ .....
b. Allergic diseases: no ☐ yes ☐ .....
a. Metabolic diseases: no ☐ yes ☐ .....
b. Cardiovascular diseases: no ☐ yes ☐ .....
c. Diseases of the nervous system: no ☐ yes ☐ .....
d. Diseases of the digestive system: no ☐ yes ☐ .....
e. Diseases of the respiratory tract: no ☐ yes ☐ .....
f. Haematological diseases: no ☐ yes ☐ .....
g. Diseases of the muscles/bones: no ☐ yes ☐ .....
h. Other diseases: no ☐ yes ☐ .....
i. Surgery: no ☐ yes ☐ .....
j. Accidents: no ☐ yes ☐ .....

Current health condition: Please detail any current physical or psychological diseases or illness requiring treatment or counselling and provide a detailed medical report in English.

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Current medication

Name of medicine	Dose	Amount	Frequency

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Please complete the vaccination record below:

VACCINE	DATE					
Diphtheria*						
Tetanus*						
Polio*						
MMR*						
Hepatitis B**						
HPV**						
COVID-19 ***						
Varicella ****						
Meningococcal C						
Other						

* Required vaccinations for school admission.
** Recommended vaccinations.
*** We reserve the right to require vaccination against COVID-19.
**** Has the child had chicken pox? If not, please consider vaccination.

Doctor's signature

Name: .....

Signature: .....

Date: .....

Contact details
(e-mail/telephone/fax) : .....