

CHILD MEDICAL REPORT

Please fill up details below				
Full Name (Please underline Surname)		Date of Birth (dd/mm/yy)		Nationality
		<div style="display: flex; justify-content: space-between;"> <div><div style="width: 20px; height: 20px; border: 1px solid black;"></div></div> <div>/</div> <div><div style="width: 20px; height: 20px; border: 1px solid black;"></div></div> <div>/</div> <div><div style="width: 20px; height: 20px; border: 1px solid black;"></div></div> <div><div style="width: 20px; height: 20px; border: 1px solid black;"></div></div> </div>		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	cm	Weight:	kg
Address in country of origin:			Name and Address of Family Doctor:	
Tel. No.:			Tel. No.:	

Please answer the following questions and tick 'N' (no) or 'Y'(yes). If 'Y' please describe							
	Y	N	DESCRIPTION		Y	N	DESCRIPTION
1. ENT (Ear, nose & throat)				11. Hay fever or other allergy			
2. Eye problems				12. Kidney disease			
3. Convulsions or fits				13. Diabetes			
4. Frequent headaches or migraine				14. Serious accident/fracture			
5. Heart abnormality				15. Congenital abnormality			
6. Bronchitis or asthma				16. Any operations(s)			
7. Severe abdominal pain				17. Tropical disease			
8. Blood in stools (motions)				18. Regular dental checks			
9. Anaemia or other blood disorder				19. Any current health problem			
10. Skin trouble				20. Any current treatment			

Has your child received common childhood vaccinations: If "yes" give dates							
	Y	N	Date		Y	N	Date
Diphtheria				Measles Mumps Rubella (MMR)			
Tetanus				Tuberculosis (BCG)			
Poliomyelitis				Typhoid			
Whooping Cough (Pertussis)				Yellow Fever			
Haemophilus Influenzae B (HiB)				Hepatitis B			

Please attach copies of important specialist reports of current interest

MEDICAL – CONFIDENTIAL
PLEASE COMPLETE YOUR CHILD’S DETAILS IN BLOCK CAPITALS

Full Name	DOB:
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(Please underline Surname)

	YES	NO
21. Was the pregnancy with this child normal?		
22. Was the delivery normal?		
23. What was the birth weight? _____ kg		
24. For children under 5 years Has there been any unusually delay (in reaching the usual milestones)? (e.g. sitting-up, crawling, walking, talking)		
25. Is the child on regular medication?		
26. For children over 5 years Is he/she attending a normal school?		

Further details of any abnormal conditions noted above:
(Please note the number of relevant question)

EDUCATION ASSESSMENT Please give details if you have replied YES to any of the following questions		
31. Have there been any problems associated with the education development of the child? Details:		
32. Has the child been referred to an education psychologist? Details:		
33. Are there any medical or educational conditions of which normal school would need to be aware? Details:		

Please read the following statement and, if you agree, kindly sign it:

STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by Shell Health and may be copied (by paper or secure electronic transmission) to the Senior Medical Office of my future Shell employing company. The Shell employing company in question may be based in a country outside the European Economic Area (EEA) and the country may therefore have a different level of protection for an individual's rights than those countries within the EEA

I declare the above information to be true to the best of my knowledge and belief.

Signature
Father or
Mother or
Guardian

Date:

		/			/		
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<input type="checkbox"/>	Fit Worldwide	Doctor signature: _____ Name (block capitals): _____ Address _____
<input type="checkbox"/>	Fit Restricted	
<input type="checkbox"/>	Temporarily Unfit	