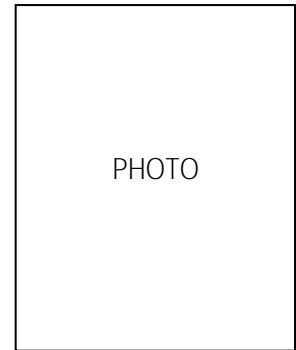




KINGDOM OF BAHRAIN
MINISTRY OF HEALTH
HEALTH CENTER/PRIVATE CLINIC



HEALTH REPORT TO THE SCHOOL

Health Center/Private Clinic: _____

Student's full name: _____

Date of Birth: ____ / ____ / _____

Age at examination: _____ years _____ months

Health Record no: _____ Family File no: _____

C.P.R no: _____ Mob. no: _____

After reviewing the vaccination card and the health record of the above mentioned student, whose photo is attached, and examining him/her by the physician concerned and the dentist, the following is/are advised:

- Fit to join the school
- Needs assessment of his/her learning capabilities

Please specify reasons: _____

Needs further assessment and/or treatment by: _____

Needs dental follow up, next appointment on: ____ / ____ / _____

Needs completion of immunization, due on: ____ / ____ / _____

Needs special care at school, because of: _____

Date: ____ / ____ / _____

Physician's Name & Signature

Dentist's Name & Signature:

