KINGDOM OF BAHRAIN
MINISTRY OF HEALTH
HEALTH CENTER/PRIVATE CLINIC

PHOTO

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:
_____
_____

HEALTH CENTER
OR PRIVATE CLINIC
STAMP