KOREA INTERNATIONAL SCHOOL

(A)

<PART 1> HEALTH INFORMATION FORM

(TO BE COMPLETED BY PARENT)

***Please return completed form to the Nurse's Office**

Student's Name	Last	First	Middle	Date of Birth (mm/dd/yyyy)	Male ( ) Female ( )	Grade:
Father's Name (Last, First)		Mother's Name (Last, First)	Home Phone	Cell Phone Father: Mother:	Emergency Contact Information Name: Relationship: Phone:	
Home Address						

HEALTH HISTORY

ALLERGIES ☐ No ☐ Yes (If yes, list specific allergy, reactions, and treatment for reactions)

☐ Food ☐ Medicine

☐ Seasonal ☐ Other

MEDICATION

Does your child take any medication on a regular basis? ☐ No ☐ Yes

☐ Medication taken at school – Name of medication:

☐ Medication taken at home – Name of medication:

HEALTH CONCERNS ☐ No ☐ Yes

☐ ADHD (Attention Deficit Hyperactivity Disorder) ☐ Asthma ☐ Autism ☐ Mental / Physical ☐ Diabetes

☐ Heart ☐ Hearing ☐ Vision ☐ Surgery ☐ Other

(If yes, please explain):

REQUIRED IMMUNIZATIONS *Please attach a copy of the immunizations report

VACCINE	DTaP (Diphtheria, Tetanus, Pertussis)		POLIO		MMR (Measles, Mumps, Rubella)		HEPATITIS B		Tdap (Tetanus, Diphtheria, Pertussis)		TB Skin Test / Chest X-ray
DATE (mm/dd/yy) EACH DOSE WAS GIVEN	2 months		2 months		12-15 months		#1		11-12 years		
	4 months		4 months		4-6 years		#2		**Varicella (Chickenpox)**		Date:
	6 months		6-18 months				#3		12-15 months		
	15-18 months		4-6 years						4-6 years		Result:
	4-6 years								Had Chickenpox disease (Yes / No)		

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATION AT SCHOOL

Over-the-counter medication may be administered in the Nurse's Office as needed with permission of the student's parent. Please check each medication for which you are giving permission.

Antipyretic medicine	☐ Tylenol	☐ Advil (Ibuprofen)
Digestant medicine	☐ Pepto-Bismol (Festal)	
Allergy medicine	☐ Zyrtec	☐ Clarityne

Print name of parent **Signature of parent** **Date** (mm/dd/yy)

Form last updated: July 2015

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<Part 2> PHYSICAL EXAMINATION CERTIFICATE

(TO BE COMPLETED BY MEDICAL DOCTOR)

(Date of Exam - within 6 months before entry to school)

______________________ ________________ ______ ____

Student's Name(Last, First, Middle) Date of Birth (mm/dd/yyyy) Gender Grade

Height_______ Weight_______ BP__________ P______ R______ T______	
Vision Screening	Rt__________ Lt__________
Hearing Screening	☐ Pass ☐ Fail
Dental Assessment	☐ No problem ☐ Problem identified: Referred for treatment
Developmental Evaluation	☐ Within normal ☐ Concern identified________________

Physical Examination	Normal	Abnormal finding	Describe in detail
Skin			
Nose and Throat			
Heart			
Lungs			
Abdomen			
Genitourinary			
Neurological			
Extremities			

Please administer the following tests:

URINALYSIS (results): ____

HEMOGLOBIN (results): ____

Tuberculin skin test (every 2 years): **Date** (mm/dd/yy) ________________ **Result** __________

A chest X-ray is required if the TB skin test result is positive.

Date (mm/dd/yy) ________________ **Result** __________

Please check for evidence of the following required immunizations.

DTaP	Polio	MMR	Hepatitis B	Varicella (Chickenpox)	Tdap
#1___	#1___	#1___	#1___	#1___	#1___
#2___	#2___	#2___	#2___	#2___	
#3___	#3___		#3___		
#4___	#4___				
#5___					

I have verified that these immunizations have been administered.

Yes_______________ No________________

Please be strict on immunizations. Administer appropriate immunization to complete.

Summary of findings (check one):

☐ Well child: no conditions identified of concern to school program/activities.

☐ Conditions identified that are important to schooling or physical activity.

(please explain): ____

____

Print name of physician ____

Signature of physician ____

Name of Clinic/Hospital ____________________ **Date** (mm/dd/yy) __________________