

STUDENT HEALTH FORM

INTERNATIONAL SCHOOL BANGKOK



PLEASE PRINT LEGIBLY IN BLOCK LETTERS

Student's Family Name: _____ First Name: _____

Middle Initial or Nick name: _____ Birthdate: day _____ month _____ year _____

Gender: Male Female School Year _____ Grade Level _____

HEALTH CONDITIONS

Yes No Does the above student have any of the following: **Diabetes, Seizures or Epilepsy, Heart Problems, Allergies** that may warrant the use of **an Epi-pen**, a condition that requires special medical assistance, or a life threatening condition?

If you checked YES, please make sure you meet with our nurses in the ISB Health Center BEFORE your child starts school. No appointment is needed.

Please indicate any of the following that apply to the above student

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| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney/ Urinary Tract Problems |
| <input type="checkbox"/> Congenital Anomalies | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Stomachaches | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Other _____ | | |

Please comment on any indicated condition(s). Specify what the problem is and provide any information that would help the school nurse better care for the student during the school day _____

Is the student able to fully participate in P.E./sports: Yes No Restricted from certain sports: _____

Allergies: _____ <small>(medication, food, and/or other)</small> Reaction: _____ _____ _____ _____	Routine Medication (s) _____ _____ Reason and frequency: _____ _____ _____
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Permission is hereby granted for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified. I certify that all information given on this record is complete and correct.

Parent Signature _____ **Date** _____

If you would like the school nurse to give your child Tylenol or its equivalent for minor aches and pains, headache, tooth ache, dental pain, menstrual cramps, or fever, please complete, sign, and date the following consent:

The ISB school nurse has my consent to give _____ (child's name), Tylenol or its equivalent during the current school year.

Parent Signature _____ **Date** _____