AIS-R STUDENT HEALTH FORM

Grade:_________________
Teacher:________________

Name:____ Birth date:______________**Sex:** M / F
Last First Middle DD/MM/YY

Compound:___________________________

List siblings attending AIS-R: Name:________________________ Grade:___________
Name:________________________ Grade:___________
Name:________________________ Grade:___________

Mother's Name:______________________
Home Phone:__________________________
Mother's Mobile:______________________
Mother's Work Phone:_________________

Father's Name:_______________________
Father's Employer:_____________________
Father's Mobile:_______________________
Father's Work Phone:__________________

Emergency contact person if parent can not be reached:
Name:_________________________ Home Phone:__________________Mobile: _________________
Name:_________________________ Home Phone:__________________Mobile: _________________

Family Doctor/
Clinic:____ Phone:____________________

In the event of an extreme medical emergency the nurse will use the closest hospital services.

The nurse has permission to administer:
(amount will be adjusted according to age level)
Please circle if YES:

Antacid **Tylenol/Panadol** **Ibuprofen/Advil** **Clarinase**
Antihistamine/decongestant
(for students 12 years
of age and over)

Past childhood disease:

- ❑ Chicken Pox
- ❑ Measles
- ❑ Mumps
- ❑ German Measles (Rubella
- ❑ Other_________________

Health conditions: (If YES, please circle and explain below):

Heart disease/disorder	Asthma	Fainting spells/dizziness
Severe headaches	Allergy	Speech difficulty
Hypertension	Vision difficulty	Musculoskeletal disorder
ADD/ADHD	Glasses/Contacts	Nosebleeds
Diabetes	Convulsions/Epilepsy	Hearing difficulty/hearing aid

See other side

State any serious condition, significant medical restrictions and/or pertinent medical information:
____
____
____
____
____
____
____
____

Please list all prescribed medication:
____
____
____

If your child has a chronic condition such as asthma, an allergy, diabetes, seizure disorder, or other please contact the school nurse.

If your child has an Allergy:
Allergic to:____
____

Vaccination History/Immunization Dates: (Or attach copy of Immunization Card)
If you have previously filled in the immunization section with dates, please only fill in any new entries. Immunization records remain in the nurse's office.
Complete with Day/Month/Year:

	1st	2nd	3rd	Booster 2-3 yrs	Booster 4-6 yrs	Booster 10-14 yrs
Diphtheria						
Tetanus						
Pertussis						
Polio						
Measles						
Mumps						
Rubella						
BCG						
TBC skin test		Pos/neg				

Meningitis						
Chicken Pox						

Medical Card Plan Name:___________________________________
Medical Card Number:______________________________________
____

I certify that, to my knowledge, the information given above is complete and accurate.

Parents Signature:____________________________________Date:________________________
____