



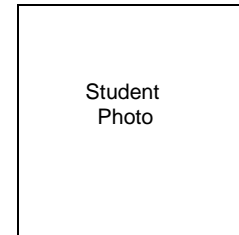
# ENGLISH INTERNATIONAL SCHOOL

Tel: 09999 38825

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## ENROLLING STUDENT HEALTH FORM



### 1. Student Information:

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

D.O.Birth: \_\_\_\_\_ Sex M/F: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Passport #: \_\_\_\_\_ Date Issued: \_\_\_\_\_ Place: \_\_\_\_\_

Last Grade Attended: \_\_\_\_\_ Last School Attended: \_\_\_\_\_

Previously Attended EIS? \_\_\_\_\_ If "Yes" Period Attended: \_\_\_\_\_

### 2. Parent Information:

FATHER

MOTHER

Name: \_\_\_\_\_

Citizenship: \_\_\_\_\_

Office Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mobile #: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Mobile #: \_\_\_\_\_

**3. Other Children in the Family:**

(List from Youngest to Eldest including applicants name)

Name	Birth Date	Sex	Attending EIS Yes or No	Applying to EIS Yes or No

**TB Status:**

Students are required to be screened for TB by PPD/Manitox Skin Test or Chest X-ray :

TB Skin Test Date: \_\_\_\_\_ Result: \_\_\_\_\_

**OR**

Chest X-ray: \_\_\_\_\_ Date: \_\_\_\_\_ Result: \_\_\_\_\_

The above requirement is waived if they have had a BCG vaccine in the last 5 years.

BCG Date: \_\_\_\_\_

**Required Immunizations (parent or physician must provide dates). You may also just attach a copy of the records instead.**

	#1	#2	#3	#4	#5
Diphtheria, Tetanus, Pertussis (often given as DPT)					
Poliomyelitis					
Measles	Often given together As MMR				
Mumps					
Rubella					

**Recommended Immunizations: (Please fill in the date)**

Hib (Heamophilus Influenza): \_\_\_\_\_ Hepatitis A: \_\_\_\_\_

Hepatitis B: \_\_\_\_\_ Varicella (chicken pox): \_\_\_\_\_

Pre-rabies series: \_\_\_\_\_ Typhoid: \_\_\_\_\_

Please list any medications that your child takes routinely or for emergency and the purpose for which they take them and frequency \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any medication to be administered by the Health Office must be sent in with written instructions. Please send a copy of the doctor's prescription. It is very important that we have your child's emergency backup medications such as inhaler, epi-pen etc.,.

## **STUDENT'S HEALTH HISTORY**

Does your child have any of the following? If yes, please supply details such as specific diagnosis and current treatment.

<b>HEALTH PROBLEM</b>	<b>YES</b>	<b>NO</b>	<b>DETAILS</b>
Allergies			
Asthma.			
Neurological Disorders Seizure disorder/epilepsy			
Diabetes			
Frequent ear infections			
Hearing difficulties			
Frequent Headaches			
Heart problems			
Kidney/Urinary Problems			
Menstrual problems			
Orthopedic (bone) problems			
Skin problems			
Eye problems			
Wears glasses/contact lenses			
Emotional problems			
Other health problems			

Blood Type: \_\_\_\_\_ Rh+ or Rh \_\_\_\_\_

Explain any limits on physical activity (especially such as shortness of breath, loss of consciousness or irregular heartbeat)

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**MEDICATION PERMISSION**

With your permission the school nurse can administer the following non-prescription medications without contacting you first.

**For all ages**

- 1. Acetaminophen for headache and minor discomfort (other names for this are Tylenol, Panadol, Paracetamol)
- 2. Strepsils throat lozenges for mild sore throat
- 3. Cough lozenges for cough
- 4. Topical ointments or solutions for minor wounds, skin irritations, and insect bites/stings

**For Middle and High School**

- 1. Ibuprofen for menstrual cramps or sprains (anti-inflammatory)
- 2. Pepto-Bismol for nausea, mild diarrhea

(Please draw a line through any you do NOT want the nurse to give)

I give my permission for the school nurse to administer these medications listed above:

Yes \_\_\_\_\_ No \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EMERGENCY PERMISSION:**

I will hereby give permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by Nurse: \_\_\_\_\_ Date: \_\_\_\_\_