ENGLISH INTERNATIONAL SCHOOL
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ENROLLING STUDENT HEALTH FORM

Student Photo

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.

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

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.

HEALTH PROBLEM	YES	NO	DETAILS
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)

_____
_____
_____
_____
_____

MEDICATION PERMISSION

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

For all ages

1. Acetominophen 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. Ibuprofin 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: _____