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JERUDONG INTERNATIONAL SCHOOL
SCHOOL HEALTH RECORD

OFFICE USE

Class/Year Group:_____

House: _____

Boarding / Day Student

Please provide details of your child's health status.
All information is confidential.

STUDENT AND FAMILY INFORMATION

Student's name: _____ Preferred name: _____
Family *First* *Second*

Male / Female Date of Birth: _____ Nationality: _____

Mother's name: _____ Contact No.: _____

Father's name: _____ Contact No.: _____

Guardian's name (if applicable): _____ Contact No.: _____

Student lives with: Both parents ☐ Mother ☐ Father ☐ Guardian ☐ Others _____
(Provide details)

BRU-HIMS Number (when in Brunei): _____
(Brunei Darussalam Healthcare Information and Management System)

EMERGENCY CONTACT *(if parents can't be reached)*

Primary contact name: _____ Relationship: _____ Contact No.: _____

Secondary contact name: _____ Relationship: _____ Contact No.: _____

Doctor/Health care provider: _____ Contact No.: _____

PERMISSION FOR EMERGENCY CARE

In the event that my child needs emergency care for an accident or sudden illness I agree to the school arranging transfer to RIPAS Hospital. I understand that I will be notified as soon as possible and that the school will not be liable for any costs incurred.

Signature: _____ _____ Date: _____
Mother/Guardian ***Father/Guardian***

PARENTAL CONFIRMATION

To provide the best health and safety care for your child it is important we have accurate and up to date information. This includes your contact details and your child's health and immunisation status. It is the parents'/guardian's responsibility to keep the school informed of any changes that occur.

I have read and understood this.

Signature: _____ _____ Date: _____
Mother/Guardian ***Father/Guardian***

STUDENT HEALTH HISTORY *(to be completed by parents)*

Does your child have a history of any health conditions?

Please complete this section before the medical officers examination:

	YES	NO		YES	NO
Neurological (Seizures, Headaches, Fainting)			Endocrinology/Hormonal (Diabetes, Thyroid)		
Heart Problems (Rhythm & Sounds)			Mouth (Teeth, Gums, Braces)		
Breathing or Lungs (Asthma, etc)			Nose (Congestion, Nose bleeds)		
Muscles, Joints, Bones, Posture			Ears (Infections, Grommets, Hearing)		
Stomach, Heartburn, Constipation			Blood Disorders: (Anemia, G6PD, Hemophillia)		
Skin Problems (Eczema, Rashes, Scars)			Allergies		
Psychological/ Emotional (Anxiety/self harm/depression)			Hospitalizations/Surgeries		
Kidney, Bladder, Urinary Infections			Nutritional Status (Over/Under weight, Eating disorder)		
Vision/Eyes			Special Dietary Requirements		

If you have answered YES to any of the above, please provide details below:
(Please provide a copy of previous medical documentation regarding previous health conditions)

1. _____

_____

2. _____

_____

3. _____

_____

PERMISSION TO GIVE MEDICATIONS

PLEASE NOTE: All medications must be dispensed from the school's Health Centre or boarding Nurse Clinic. No student is to carry medication on their person, in their school bag, or keep in their locker or boarding house room without the knowledge and prior permission of the school nurse.

Student's own medication(s) should be clearly labelled with name, directions for use and handed in to the Health Centre or boarding Nurse Clinic where they will be stored safely and dispensed as requested.

Wherever possible, Junior School parents will be contacted prior to administering any medication.

Please indicate your permission for the following medication to be used by the Health Centre and Boarding Nurse Clinic:

Panadol	Yes ☐	No ☐	Panadol Menstrual	Yes ☐	No ☐	Ibuprofen	Yes ☐	No ☐
Antihistamine	Yes ☐	No ☐	Decongestant	Yes ☐	No ☐	Cough syrup	Yes ☐	No ☐
Throat lozenges	Yes ☐	No ☐	Antacid	Yes ☐	No ☐			

Creams for bruising/skin complaints/burns Yes ☐ No ☐

Comments:

Signature: _____ _____ Date: _____

Mother/Guardian *Father/Guardian*

PHYSICAL EXAMINATION *(To be completed by a Medical Doctor / Nurse Practitioner)*

Height: _____	Blood group (if known): _____	Vision	Hearing
Weight: _____	Pulse: _____	R: _____	R: _____
BMI: _____	BP: _____	L: _____	L: _____
		Wears corrective lens Yes ☐ No ☐	

	ABNORMAL	NORMAL		ABNORMAL	NORMAL
Neurological (Seizures, Headaches, Syncope)			Endocrinology/Hormonal (Diabetes, Thyroid)		
Neurological (Seizures, Headaches, Syncope)			Mouth (Teeth, Gums, Braces)		
Respiratory/Pulmonary (Asthma, Tb, Cystic Fibrosis)			Nose (Congestion, Nose bleeds)		
Musculo Skeletal (Postural, Joint Problems)			Ears (Infections, Grommets, Hearing)		
Gastrointestinal (Upper & Lower GI)			Blood Disorders: (Anemia, G6PD, Hemophillia)		
Integumentary (Eczema, Rashes, Scars, Psoriasis)			Allergies		
Urological			Nutritional Status (Over/Under weight, Eating disorder)		
Psychological			Hospitalizations/Surgeries		
Vision/Eyes					

Describe any abnormalities or conditions listed above and the dates involved:

1. _____

_____

2. _____

_____

3. _____

_____

This student is able to participate in all physical education activities. Yes ☐ No ☐

If not, please explain: _____

_____

_____

Regular or PRN MEDICATIONS Yes ☐ No ☐

Name, dose and reason for medication: _____

1. _____

2. _____

Please provide immunisation details over the page

IMMUNISATION *(Transcribe from immunisation records **and attach photocopy**)*

	DATES				Course Complete (for age)		Comments
Polio					Yes	No	
DPT					Yes	No	
MMR					Yes	No	
HIB					Yes	No	
TB					Yes	No	
Hepatitis A					Yes	No	
Hepatitis B					Yes	No	
Varicella					Yes	No	

Others

1. _____
2. _____
3. _____
4. _____

Physician's signature and title: _____ Date: _____
(Stamp)
Address: _____

Phone Number: _____

MEDICAL INSURANCE INFORMATION

All non-Bruneian Students are recommended to have full medical insurance. Please attach a copy and a copy of medical insurance card.

Medical Insurer's Name: _____

Address: _____

_____

_____

Contact Number: _____

Policy Number: _____