CHIST
CHIYODA INTERNATIONAL SCHOOL TOKYO

May 18, 2019

*CHIST:

Student Health Form

Student Information

Student's Name _____
(Passport name) (Family) (First) (Middle)

Date of Birth _____/_____/_____ Male_____ Female_____ Current Grade _____
month day year

Emergency Contact Information

1. Emergency Contact Person: Name_____ Relationship to Student _____
Home Phone_____ Work _____ Mobile _____
2. Emergency Contact Person: Name_____ Relationship to Student _____
Home Phone_____ Work _____ Mobile _____

Medical History

1. Does the student have any current medical conditions? Please complete the table with a check (✓). Attach additional pages if required.
   ☐ ADD/ADHD ☐ Asthma ☐ Diabetes ☐ Major Surgery/Accidents
   ☐ Allergies ☐ Congenital Anomalies ☐ Heart Disease ☐ Other _____
   If yes, please provide details of your condition(s).

_____
_____
_____
_____

2. Is the student currently taking any medication? Yes/ No
   If yes, please list the student's current medication(s).

_____
_____
_____

3. Does the student have any problems with hearing or vision? Yes/No
   If yes, please provide details.

_____
_____
_____

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4. Does the student have any health problems that restrict his or her participation in physical education, music, or any other school activities? Yes/ No
   If yes, please provide details.

_____

_____

_____

_____

5. Indicate with a check (✓) if you have had the following.
   ☐ Chickenpox ☐ Mumps ☐ Rubella (German Measles)
   ☐ Measles ☐ Pertussis (Whooping cough) ☐ Tuberculosis

6. Immunization Record: Please supply the dates (mm/dd/yy) of each immunization you have received. You may attach a copy of an official immunization record.

DPT-Diphtheria/Pertussis/Tetanus	1. ___/___/___	2. ___/___/___	3. ___/___/___	4. ___/___/___
Polio	1. ___/___/___	2. ___/___/___		
MR (Measles/Rubella)	1. ___/___/___	2. ___/___/___		
DT-Diphtheria/Tetanus Age 12	1. ___/___/___			
Rubella	1. ___/___/___			
Measles	1. ___/___/___			
BCG	1. ___/___/___			

Any additional vaccinations:

_____

_____

_____

7. Medical Permission

   I hereby give permission for my child to be given temporary medication by the school nurse. Medication used in the nurse's office may include, but is not limited to paracetamol, acetaminophen and ibuprofen.
   ☐ Yes ☐ No

8. Accident Treatment Permission

   Understanding that my child may need emergency medical treatment during school hours or at school related activities, I give CHIST personnel permission to seek such treatment for my child as they see fit; and I expect to be contacted and consulted as soon as possible in the event of such an emergency.
   ☐ Yes ☐ No

   I certify that all information above is correct and complete.

_____

Signature of Parent/Guardian Date