CONCORDIA
INTERNATIONAL SCHOOL HANOI

Health Information Form

SECTION 1- TO BE COMPLETED BY PARENT/GUARDIAN

This form is REQUIRED for ALL Concordia students, prior to the start of EVERY school year for RETURNING STUDENTS or your child's first day of school if a NEW STUDENT. This Health Information Form must be returned prior to orientation day (Send scans to jaylyn.tan@concordiahanoi.org).

_____ MM/DD/YYYY _____ _____ _____ M / F

(Student's Name: Last, First Middle) (Date of Birth) (Age) (Grade) (Sex)

_____ _____ _____

(Address) (Phone)

Has this student ever had surgery or been hospitalized? No Yes
If yes, please explain the details of the surgery or hospitalization _____
_____

Returning Students: Are there any changes in your child's health status? (new allergies, health conditions, etc.) No Yes
If yes, please explain: _____

PERMISSION TO ADMINISTER BASIC MEDICATIONS

In case of sudden illness or injury, the Health Office is able to administer basic medications to your child, however, YOUR CONSENT IS REQUIRED.

I consent for my child to be given the following non-prescription medications by school staff/personnel as needed at school or on school-related off-campus events:

Check all that apply:

✓	***Name and Use for Basic Medications***
	Acetaminophen/Paracetamol - for PAIN RELIEF and FEVER
	Ibuprofen - for PAIN RELIEF (especially with musculoskeletal injuries) and FEVER
	Calcium Carbonate (chewable antacids) - for STOMACH DISTRESS caused by indigestion
	Bismuth Subsalicylate (students >12 years) - for STOMACH DISTRESS, NAUSEA, and MILD DIARRHEA
	Diphenhydramine (antihistamine) - for non-life threatening allergic reaction (*NOTE: known to cause drowsiness)
	Throat lozenges - for relief of SORE THROAT due to minor upper respiratory infections (common cold)
	Topical Triple Antibiotic Ointment (Bacitracin Zinc, Neomycin Sulfate, Polymycin B Sulfate) - helps prevent infection in minor cuts, scrapes and burns
	Topical Hydrocortisone 1% cream - for temporary relief of itching due to minor skin irritations, inflammation, and rashes from insect bites
	Saline eye drops (NaCl 0.9%) - for eye irrigation
	Benzocaine 20% (oral analgesic gel)- for temporary relief of pain due to toothaches and mouth sores

FAMILY CONTACT INFORMATION

_____ _____

(Mother's Last/ First Name) (Father's Last/ First Name)

_____ _____

(Mother's Phone) (Father's Phone)

Names and Grades of any siblings attending Concordia International School Hanoi:

Sibling Name	Grade

LOCAL EMERGENCY CONTACT INFORMATION

Must be HANOI-BASED ADULTS who are NOT the student's parents. If parents cannot be reached using all means available, these designated emergency contacts have your permission to make health care decisions on your behalf. Please ensure that these contacts are aware of your preferred Hanoi medical clinic and your child's medical history.

(First Emergency Contact Last/ First Name)	(Second Emergency Contact Last/ First Name)
(Relationship to Student)	(Relationship to Student)
(First Emergency Contact's Phone)	(Second Emergency Contact's Phone)

EMERGENCY CARE PERMISSION

In the event that my child has an accident/injury or illness while on the Concordia International School Hanoi campus or on authorized field trips or activities outside of the school campus, the chaperones/staff personnel will make every effort to contact me or my spouse or alternate emergency contact designated by me prior to medical treatment or hospitalization. If hospitalization is required, any procedures, surgery, or anesthesia that may be necessary to save the life of my child may be done after receiving telephone consent from myself or my spouse or alternate emergency contact designated by me.

If reasonable efforts to contact myself, my spouse, or other alternate emergency contact designated by me are unsuccessful, the Concordia International School Hanoi and its chaperones/staff personnel are authorized to:

- take my child to seek medical/dental care;
- to consent to any procedure, surgery, or anesthesia, if, in the judgment of the medical staff, such treatment is needed to save the life of and treat the emergency medical conditions of my child;
- complete and provide signatures on forms and other documents necessary to facilitate the above needed medical procedure; and
- incur any medical, hospital and ambulance expenses on my behalf as a result of such injury or illness, including those that may not be covered by my insurance.

By signing below, I acknowledge that the above authorization shall be valid while my child is/children are attending school at Concordia International School Hanoi unless expressly revoked by me in writing. I further acknowledge that I am responsible for updating the contact information and student health information provided herein to Concordia International School Hanoi, and that all information I have provided on this document is complete and correct.

CONCORDIA
INTERNATIONAL SCHOOL HANOI

Signature of Parent or Guardian

Name of Parent or Guardian PRINTED

Date

SECTION 2- TO BE COMPLETED BY A PHYSICAN

CONCORDIA STUDENTS:

NEW STUDENTS: In order to begin attendance, this health form must be completed by a physician and dated after FEBRUARY 15 prior to your first day of school.

RETURNING STUDENTS: This health form must be completed by a physician and dated after FEBRUARY 15 prior to the first day of school EVERY 3 YEARS upon re-enrollment.

TO THE PHYSICIAN: Please make a physical examination of the below-named pupil and use the codes indicated in marking the conditions.

_____ _____ _____ _____ _____

(Student's Name: Last, First Middle) (Date of Birth) (Age) (Grade) (Sex)

Height:_____ (cm/in) Weight:_____ (kg/lb) Pulse:_____ BP:_____

CODE- No Defects: O; Defects: X. Immediate Attention Desired: XX; Under Treatment: T; Corrected: C

Eyes (condition)		Nutrition		Muscle Tone	
Eyes (vision)		Scalp/ Hair		Thyroid	
with glasses	L R	Heart/Circulation		Lungs/ Chest	
with contacts	L R	Nervous System		Lymph	
color perception	L R	Skin		Abdomen	
Ears		Speech		Dental	
Throat		Orthopedic		Menses	
Nose		Scoliosis		Other	

STUDENT MEDICAL HISTORY: To be reviewed with the parent by a physician (please circle all applicable conditions). If you answer yes to any of the below items or for any additional medical concerns, please explain in the box below:

Allergies (food, medications, insects, etc.)	No	Yes	If yes, does student use an Epi-Pen?
Asthma	No	Yes	If yes, does student use an inhaler? Type?
Diabetes	No	Yes	Please provide details of any medical concerns here:
Epilepsy/ Seizure Disorder	No	Yes	
ADD/ ADHD	No	Yes	
Anxiety Disorder	No	Yes	
Chicken Pox	No	Yes	
Gastrointestinal Disorder	No	Yes	
Frequent Nosebleeds	No	Yes	
Frequent Headaches	No	Yes	
Hearing Problems	No	Yes	
Heart Disorder	No	Yes	
Hepatitis A / B / C	No	Yes	
Scoliosis	No	Yes	
Skin Problems	No	Yes	
Speech Problems	No	Yes	
Vision Problems	No	Yes	
Other Illness or Concerns	No	Yes	

PHYSICAL ACTIVITIES: (Normal Physical Education Classes, Swimming, and Competitive Sports)

Unrestricted _____ Modified _____ If modified, how? _____

Reason for Modification: _____

Concordia has a ***mandatory*** vaccination and immunization policy. Please attach an official copy of the student's immunization record or a physician must complete the table below..

Please complete the following table with the exact dates the immunization was received.

REQUIRED

Name of Vaccination	Date Given	Date Given	Date Given	Date Given	Date Given	Date Given
Diphtheria/ Pertussis/ Tetanus containing vaccine *3 doses (between 2 mos.-12 mos.) AND* *3 boosters(DTP 12-24 mos./ Tdap 4-7yrs/ Tdap 9-15yrs.)*	M M / D D / YYYY	M M / D D / YYYY	M M / D D / YYYY	M M / D D / YYYY	M M / D D / YYYY	M M / D D / YYYY
Measles/ Mumps/ Rubella *MMR 2 doses (4 weeks between)*	M M / D D / YYYY	M M / D D / YYYY				
Polio, 3-4 doses *(IPV 3 doses OR OPV + IPV 4 doses OR IPV/OPV sequential 3-4 doses)*	M M / D D / YYYY	M M / D D / YYYY	M M / D D / YYYY	M M / D D / YYYY		
Although not mandatory Concordia requirements, the following vaccinations are highly recommended for all people living in Vietnam: Hepatitis A; Hepatitis B; Rabies, Japanese encephalitis, Meningococcal, Typhoid, and flu.						

TUBERCULOSIS SCREENING:

Required for all new students and then every 3 years for currently enrolled students, ***regardless*** of previous BCG vaccine.

☐ PPD Test Taken Results:_____ Date:_____

[If PPD results are positive, chest X-Ray is ***required***.]

☐ Chest X-Ray taken (only if PPD test is positive) Chest X-Ray results: _____

MEDICATION: Is the student taking any medication (oral or injection) on a regular basis?

☐ No ☐ Yes If yes, name(s), dosage(s), and frequency _____

_____

STAFF PERSONNEL- ADMINISTERED MEDICATIONS:

If any medications are to be administered to this students by staff personnel, please provide a copy of the doctor's prescription as well as the following written instructions.

Name of Medication: _____ Dosage:_____

Time to Administer: _____ Number of times to be administered daily:_____

Physician Details:

Signature_____

Name (Please use CAPITAL letters): _____

Name and Address of Medical Office: _____

Date of Examination: _____

Telephone (Country and Area Code): _____

Official Stamp