AISB 2019 - 2020

STUDENT MEDICAL INFORMATION

Please note a copy of your child's vaccination record must be Submitted with this form

Student Name: _____ Date: _____

Date of Birth: _____ - _____ - _____ Female ☐ Male ☐

Month Day Year

Blood Type: _____ Medication(s) taken regularly: _____

_____

Health History

	Yes	No		Yes	No
Abdominal complaints	☐	☐	Injuries, Burns	☐	☐
Allergies	☐	☐	Kidney Disorders	☐	☐
Bronchial Asthma	☐	☐	Malaria	☐	☐
Chickenpox	☐	☐	Measles	☐	☐
ENT (Ear/Nose/Throat)	☐	☐	Menstrual Problems	☐	☐
Epilepsy	☐	☐	Mumps	☐	☐
Eye Problems	☐	☐	Neurological Disease	☐	☐
Food Allergies	☐	☐	Polio	☐	☐
Fever	☐	☐	Rheumatic Fever	☐	☐
Fractures	☐	☐	Rubella	☐	☐
Genital Abnormalities	☐	☐	Scarlet Fever	☐	☐
Headaches	☐	☐	Sickle Cell Anemia	☐	☐
Head Injuries	☐	☐	Skin &/or Scalp Infections	☐	☐
Heart Disease	☐	☐	Tuberculosis	☐	☐
Hepatitis	☐	☐	Urinary Disorders	☐	☐

Please explain: _____

_____

_____

_____

_____

Student Medical Information

1. Please provide any other health information of which we should be aware: _____

_____

_____

2. Please indicate any adverse reactions to vaccines: _____

3. Has your son/daughter ever undergone surgery? Yes ☐ No ☐

   If yes, please explain: _____

   _____

4. Has your son/daughter ever been hospitalized? Yes ☐ No ☐

   If yes, please explain: _____

   _____

5. Does your son/daughter wear glasses? Yes ☐ No ☐ Contact lenses? Yes ☐ No ☐

6. Is your son/daughter allergic to any prescribed medications (i.e. penicillin)? Yes ☐ No ☐

7. Does your son/daughter have any physical disability, which would prohibit him/her from participating in our physical education program or on our sports teams? Yes ☐ No ☐

   If yes, please explain: _____

   _____

I hereby grant AISB permission to:

☐ administer non-prescriptive medications to my son/daughter.

☐ admit my son/daughter to a hospital/clinic in case of an emergency.

_____ _____

Parent Name Printed Parent Signature

_____

Date

NOTE: A copy of your child's immunization records must accompany this form.