the American International School in Egypt

STUDENT HEALTH RECORD

NAME: _____
FIRST MIDDLE FAMILY

BIRTHDATE: _____/_____/____-___ GRADE: _____ SEX:_____

Place Photo Here

FATHER: _____
FIRST FAMILY

MOTHER: _____
FIRST FAMILY

ADDRESS: _____

_____

_____

EMAIL: _____

PHONE: HOME:_____

WORK: FATHER: _____MOTHER: _____

MOBILE: FATHER: _____ MOTHER:_____

EMERGENCY CONTACT (if unable to contact parents)

1. _____ PHONE_____

2. _____PHONE:_____

OTHER CHILDREN AT AISW:

1._____ GRADE: _____

2. _____GRADE: _____

3. _____GRADE: _____

MEDICAL HISTORY

Does your child currently have or has he/she had any of the following health problems?

Please check as necessary.

*	Allergies	□ Yes	□ No
	Peanut Allergy	□ Yes	□ No
	G6PD (Favism)	□ Yes	□ No
	Penicillin	□ Yes	□ No
	Others	Specify _____	
*	Asthma	□ Yes	□ No
*	Blood diseases	□ Yes	□ No
*	Congenital anomalies (birth defects)	□ Yes	□ No
*	Diabetes (high blood sugar)	□ Yes	□ No
*	Hearing problems	□ Yes	□ No
*	Heart problems	□ Yes	□ No
*	Orthopedic (bone) problems	□ Yes	□ No
*	Operations	□ Yes	□ No
*	Rheumatic fever	□ Yes	□ No
*	Seizures	□ Yes	□ No
*	Speech problems	□ Yes	□ No
*	Skin problems	□ Yes	□ No
*	Visual (eye) problems	□ Yes	□ No
*	Others, please specify: _____		

Does your child require any medications on a regular basis? □ Yes □ No

Please specify _____

Are there any restrictions in terms of diet, medication, or lifestyle? □ Yes □ No

Please specify _____

IMMUNIZATION HISTORY

Please fill in the date of immunization or submit a copy of the immunization card.
If the child has had the disease please specify the date.

Date of Immunization						
Vaccine	1st	2nd	3rd	1st booster	Last booster	Disease
BCG						
DPT Td						
HEP B						
POLIO						
MEASLES						
MMR						
VARICELLA						
Hib						
PNEUMOCOCCAL						
Rota						
HEP A						
MENINGITIS						
INFLUENZA						

CODE:

BCG - for TB
DPT - Diphtheria, pertussis, and tetanus (Al- Thoulathy)
Td - Tetanus, diphtheria
Hep B - Hepatitis B
MMR - Measles, Mumps, Rubella
Varicella - for Chicken Pox
Meningitis - Meningococcal ACWY 135 Vaccine

FAMILY HISTORY

Is there a family history of blood diseases, diabetes, epilepsy, seizures, or others?

_____

Please specify _____

The school has my permission to give my child non-prescription medications.

□ Yes □ No

Name of Pediatrician / Family Doctor: _____

Phone: _____

In case of a medical emergency concerning my child at school, I understand that all efforts will be made to contact me, my spouse, or the emergency contact person on record. If the school is unable to speak directly with me, my spouse or the emergency contact person, I hereby authorize the school doctor to administer or obtain necessary medical treatment for my child. I understand that any medical treatment administered at school will be limited to First Aid, and any additional treatment required will also be administered by a competent medical professional. I also understand that my child will be taken to a hospital if it is necessary.

Preferred Hospital: _____

Name of Parent / Guardian: _____

Signature of Parent / Guardian: _____

Date: _____