



the **American International School in Egypt**

STUDENT HEALTH RECORD

NAME: _____
FIRST MIDDLE FAMILY

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

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 _____

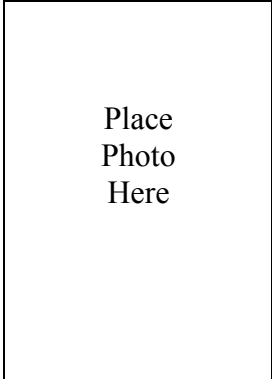
2. _____ PHONE: _____

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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Peanut Allergy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G6PD (Favism) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Others | Specify _____ | |
| * Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Blood diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Congenital anomalies (birth defects) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Diabetes (high blood sugar) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Hearing problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Heart problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Orthopedic (bone) problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Operations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Rheumatic fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Speech problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Skin problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| * Visual (eye) problems | <input type="checkbox"/> Yes | <input type="checkbox"/> 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.

Vaccine	Date of Immunization						Disease
	1st	2nd	3rd	1st booster	Last booster		
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: _____