Seoul International School
AUTHORIZATION FOR MEDICAL PROCEDURE

NAME OF STUDENT:_____ **D.O.B.:**_____ **HOMEROOM/GRADE:** _____

SIS requires that your child is immunized and receives a comprehensive physical examination BEFORE entering SIS. Please return this form to school PRIOR TO the student's start date at SIS.

PART 1: PARENT/GUARDIAN AUTHORIZATION

- I hereby certify, to the best of my knowledge, that the information I have provided in this form is true and correct. If false or not updated or misleading the information has been provided, SIS has the right to annul my child's enrollment at SIS.
- I request medication(s) be given during school hours as ordered by my child's physician. I also request the medication(s) be given to the field trips, as prescribed.
- I will notify the school of any change in the medication(s).
- I give permission for the medications to be given by the school personnel as delegated, trained, and supervised by the school nurse.
- I give permission for the school nurse to communicate, as needed, with school staff about my child's medical conditions(s) and the treatment prescribed.
- It is parental responsibility to update medical records every 3 years.

PART 2: EMERGENCY CARE PERMISSION

- Permission is hereby given for emergency measures to be taken in case of an accident or sudden illness with the understating that I will be notified as soon as possible.
- I acknowledge that it is my responsibility to inform the Seoul International School Health Office of any changes in my child's health, physical condition, or medical needs.
- I give permission to SIS to release appropriate medical information to the hospital in case of an emergency.

PARENT/GUARDIAN SIGNATURE:_____ **Date:**_____

Seoul International School

STUDENT MEDICAL HISTORY & HEALTH FORM

TO BE COMPLETED BY THE PARENT OR GUARDIAN and bring ALL parts of this Form to your child's physician to make confirm.

STUDENT INFORMATION				
STUDENT'S NAME (Last, First):	DATE OF BIRTH (MM/DD/YYYY):	BLOOD TYPE:	SEX:	HOMEROOM (GRADE):
			Male ( ) Female ( )	
Father/Guardian's Name (Last, First):	Cell #:	Mother/Guardian's Name (Last, First):		Cell #:
Home Address:	Home Phone #:	Email :		

Emergency Contact (Other than parents):

Name:_____(Relation:) Contact number: _____

PAST OR PRESENT MEDICAL HISTORY							
Does the child/student have a past or present medical history of the following?							
ADD/ADHD	☐ Y ☐ N	Epilepsy/Seizure Disorder	☐ Y ☐ N	Hearing Problems	☐ Y ☐ N	Skin Problems	☐ Y ☐ N
Anxiety Disorder	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Heart Disorder	☐ Y ☐ N	Speech Difficulty	☐ Y ☐ N
Chicken Pox	☐ Y ☐ N	Frequent Nosebleeds	☐ Y ☐ N	Hepatitis A/B/C	☐ Y ☐ N	Vision Problems	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Gastrointestinal Disorder	☐ Y ☐ N	Scoliosis	☐ Y ☐ N	*Others:* _____	☐ Y ☐ N

If you have checked on any of the above medical history, please explain in detail:

Does your child have allergies? ☐ Y ☐ N	
If YES, student is allergic to:	
Reactions the student may have:	
Treatments the student may need after exposure:	
Does your child have asthma? ☐ Y ☐ N	
If YES, does the student need an inhaler?	☐ Y ☐ N
If the student needs an inhaler, please indicate if the inhaler will:	☐ remain with the student or ☐ be provided to the Health Office for emergency use.

If your child have other significant health conditions that may require emergency medical care at school, child care, field trip or sports activity, please explain in detail:

Seoul International School

STUDENT MEDICAL HISTORY & HEALTH FORM

TO BE COMPLETED BY THE PARENT OR GUARDIAN and bring ALL parts of this Form to your child's physician to make confirm. Please return this form to nurse office PRIOR TO the student's start date at SIS.

PART 3: Medication Authorization

NAME OF STUDENT:_____ **D.O.B.:**_____ **HOMEROOM/GRADE:** _____

Medication Permission			
Please check the following list of common medications which Health Office may administer to your child as needed at school.			
Acetaminophen (Tylenol) - pain and fever relief	☐ Y ☐ N	Hexamedine/Tantum spray for sore throat	☐ Y ☐ N
Ibuprofen (Advil) - pain relief and anti-inflammatory	☐ Y ☐ N	Cegaton Troche - sore throat, stomatitis	☐ Y ☐ N
Zyrtec (tablet) - allergy (Nasal/Sinus Congestion)	☐ Y ☐ N	Festal Plus— stomach indigestion	☐ Y ☐ N
Almagel suspension- Antiacid	☐ Y ☐ N	Smecta suspension- stomach pain and diarrhea	☐ Y ☐ N
Please list any medication the student takes on a regular basis at home:			

This is ONLY for the student who needs to prepare SELF-medication(s) at the nurse's office during school hours for an emergency use related to the child's current disease and/or condition. (Ex: Asthma-Inhaler, Allergy-EPIPEN, Diabetics, Insulin/Glucagon, etc.)

Physician order for administration of medication by school personnel:

Medical Condition(s):

Name of Medication:			Name of Medication:		
Dose:	*Time to given:*	*Route:*	*Dose:*	*Time to given:*	*Route:*
Possible side effects:			*Possible side effects:*		
Start date:	*Stop date:*	*Refrigeration required?*	*Start date:*	*Stop date:*	*Refrigeration required?*
Physician Signature:	*Date:*		*Physician Signature:*	*Date:*	
Clinic:	*Phone:*		*E-mail/ Fax:*		

PARENT/GUARDIAN SIGNATURE:_____ **Date:**_____

PHYSICIAN'S EXAMINATION
(MEDICAL EXAM MUST BE WITHIN 6 MONTHS OF ENTRY DATE)

Name (Last, First) _____ Grade _____ Date of Birth (MM/DD/YY) _____

Sibling at SIS (name/grade) _____

Height _____cm Weight _____Kg Pulse _____

Vision R:_____L:_____ Both _____

Blood Pressure _____ /_____ Corrective Lens □ YES / □ NO

(Blood Pressure only for students age 11 and older)

(O) Normal (X) Abnormal (Comment: Specify consultation requested)

Ears/Hearing		Musculoskeletal	
Nose		Spine	
Mouth		Skin	
Throat		Neurological	
Neck		Nutritional	
Heart		Emotional / Psychological	
Lungs		Behavior	
Abdomen		Speech	

Physician's Comments :

_____

_____

Please list any medication the student takes on a regular basis.

_____

This student is physically able to participate in all physical education and sports activities : □ YES / □ NO

If NO, Please explain : _____

If TB skin test result is positive, either chest X-ray or TB blood test(IGRA) is required regardless of previous BCG vaccination. - All students enrolled at SIS are required to have PPD skin test OR chest X-ray OR IGRA every 2-3 years.

Required tests	Date (MM/DD/YY)	Result
Tuberculosis Skin Test or Chest X-ray or IGRA		TB skin test: Chest X-ray: TB blood test(IGRA):
HEMOGLOBIN (6yrs old~)		
URINALYSIS (6yrs old~)		

SIS requires evidence of immunization for the following.

I have seen evidence that these have been administered. □ YES / □ NO

* Please indicates the EXACT DATES (MM/DD/YY) of vaccinations received.

DT&P #1__/__/__ #2__/__/__ #3__/__/__ #4__/__/__ #5__/__/__

OPV/IPV #1__/__/__ #2__/__/__ #3__/__/__ #4__/__/__

Varicella #1__/__/__ #2__/__/__ # Dz__/__/__

MMR #1__/__/__ #2__/__/__

HepB #1__/__/__ #2__/__/__ #3__/__/__

Td/ 11-12 years

Tdap #1__/__/__

NOTE TO THE PHYSICIAN : Please be strict on immunization. Students who have lost records must have the OPV booster, one DTap or Td (if between ages 11 and 18) booster, and one MMR booster along with the annual Tuberculin Skin Test. Please administer appropriate immunization for incomplete records. Thank you.

Physician's Name	Signature
Hospital	Date