



HARROW
INTERNATIONAL
SCHOOL
BANGKOK

Student Health Record

(To be **completed by parents/guardian** and submitted with the Application Form)

| STUDENT DETAILS | | | | | | | | | | | |
|---|---------------|---|-----------------|-----------|--------|------------|--------|---------------|--------|----------|--------|
| Forename: | Surname: | Nickname: | (Photograph) | | | | | | | | |
| Full name in Thai (if applicable): | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | | | | | | | |
| Date of Birth: | Nationality: | Year Group: | | | | | | | | | |
| Child's home address: | | Phone (Home): | | | | | | | | | |
| First Language: | | | | | | | | | | | |
| PARENT CONTACT DETAILS | | | | | | | | | | | |
| Full name | Email: | Phone (Mobile) | Phone (Work) | | | | | | | | |
| Mother: | | | | | | | | | | | |
| Father: | | | | | | | | | | | |
| Guardian: | | | | | | | | | | | |
| MEDICAL HISTORY | | | | | | | | | | | |
| Does your child have any medical history? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please tick the list below) | | | | | | | | | | | |
| <input type="checkbox"/> | G6PD / Anemia | <input type="checkbox"/> | Diabetes | | | | | | | | |
| <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Epilepsy | | | | | | | | |
| <input type="checkbox"/> | Concussion | <input type="checkbox"/> | Heart disease | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Kidney Disease | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Ear Conditions | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Thyroid Disease | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Vision Problems | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Tuberculosis | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Migraine | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Pertussis | | | | | | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | Lung Disease | | | | | | | | |
| Any health needs or special care required: | | | | | | | | | | | |
| Has your child had a medical diagnosis or had an operation? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please give details and date) | | | | | | | | | | | |
| Current medication: | | | | | | | | | | | |
| Allergies to food/medication: | | | | | | | | | | | |
| Medication used to treat allergies: | | | | | | | | | | | |
| ASTHMA | | | | | | | | | | | |
| <ul style="list-style-type: none"> Does your child suffer from asthma? Yes / No If yes, what triggers an asthma attack? <table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">Allergies</td> <td style="width: 25%;">Yes/No</td> <td style="width: 25%;">Virus/Cold</td> <td style="width: 25%;">Yes/No</td> </tr> <tr> <td>Environmental</td> <td>Yes/No</td> <td>Exercise</td> <td>Yes/No</td> </tr> </table> What asthma medication does your child take on a regular basis, please list medicine name, dosage and frequency of all medication. What inhaler/puffer does your child use when he/she has an asthma attack? Does your child know how to use his/her inhaler? Yes / No Does your child carry an asthma inhaler his/her backpack? Yes / No Does your child have an inhaler in the medical unit? Yes / No When was your child's last asthma attack? (Date) How frequently does your child experience asthmatic attacks? Other information | | | | Allergies | Yes/No | Virus/Cold | Yes/No | Environmental | Yes/No | Exercise | Yes/No |
| Allergies | Yes/No | Virus/Cold | Yes/No | | | | | | | | |
| Environmental | Yes/No | Exercise | Yes/No | | | | | | | | |
| We encourage students to leave a dosage of any routine or emergency medications (inhaler, EpiPen, etc.) in the medical unit with written instructions including name of the student, Year and time of administration. | | | | | | | | | | | |

ANAPHYLAXIS CONDITION

Does your child have a history of anaphylaxis: Yes / No

He/She has a **severe, life-threatening** allergy to the following (if appropriate, please state):

-
-
-

The nature of the reaction (please select boxes that are applicable):

- Physical contact with this allergen may cause an anaphylactic reaction
- Airborne contact with this allergen may cause an anaphylactic reaction
- Ingestion of food may cause an anaphylactic reaction
- Other:

Please select the following symptoms that may apply to your child:

| MILD CONDITION | | SEVERE CONDITION | |
|--------------------------|----------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | Itchy Mouth | <input type="checkbox"/> | Swollen Lips/Tongue/Throat |
| <input type="checkbox"/> | Cough and Sneezing | <input type="checkbox"/> | Difficulty Breathing/Wheezing |
| <input type="checkbox"/> | Itchy Eyes/Swollen Eyelids | <input type="checkbox"/> | Abdominal Cramps |
| <input type="checkbox"/> | Flush/Pallor Change | <input type="checkbox"/> | Heavy Sweating |
| <input type="checkbox"/> | Nausea/Vomiting | <input type="checkbox"/> | Edema |
| <input type="checkbox"/> | Skin Hives/Rash | <input type="checkbox"/> | |
| Other symptoms: | | | |

Please indicate the medication to be given for allergy symptoms at school:

| CONDITION | SYMPTOMS | MEDICATION REQUIRED |
|---|----------|---------------------|
| Mild to moderate reaction | | |
| Severe reaction | | |
| Does your child need an adrenaline (epinephrine) injection should they have a severe reaction at school? YES / NO (If yes, please state dose required). | | |

EMERGENCY MEDICAL TREATMENT CONSENT

In the event of an emergency or student illness, for the student named above, the school nurse:

- Is allowed to administer first aid care
- Is allowed to supply non-prescription medicines (e.g. Tylenol)
- Is **not allowed** to supply non-prescription medicines (e.g. Tylenol)
- May administer oral medication/inhaler and **adrenaline (epinephrine)** in an emergency situation if noted above.
If adrenaline (epinephrine) is required, it should be delivered promptly, the student sent to hospital and parents informed.
- Can share the student's picture and medical information with specific school personnel on a need-to-know basis.

I understand that I will be contacted in the event of a medical emergency. I will provide the school with accurate and up to date health information about my child throughout the year. I understand the school nurse will give the appropriate care to my child.

Note: In the event of a medical emergency, this form will accompany your child to the hospital so that medical treatment can be given.

Full name: Relationship to child:

Signature: Date:

Record of Medical Examination

(To be **completed by a doctor** after your child has been accepted by Harrow Bangkok for **Pre Nursery-Year 13**)

| Full name: | | | Nickname: | | DOB: |
|--|------------------|-----------------------------|--------------------------|------------------------------|----------------|
| Vaccine | Vaccination Date | Completed Date | Vaccine | Vaccination Date | Completed Date |
| BCG (Tuberculosis) | | | Hepatitis A | | |
| Poliomyelitis | | | Hepatitis B | | |
| Mumps | | | Japanese B Encephalitis | | |
| Measles/Rubella | | | Typhoid | | |
| DPT (diphtheria, tetanus, whooping cough) | | | Other | | |
| Eye Check | | | | Specialist name/Stamp | |
| Glasses: Wears/Needs | | Contact Lenses: Wears/Needs | | | |
| Vision: Right Eye: | | Left Eye: | | | |
| Colour Blindness: | | | | | |
| Dental | | | | | |
| Findings: | | | | | |
| Recommendation: | | | | | |
| Audiometric Hearing Test (By an ENT Specialist) | | | | | |
| Right Ear: | | Left Ear: | | | |
| Recommendation: | | | | | |
| Physical examination (By Physician) | | | | | |
| Blood Pressure: mm/Hg | | Height: cms | | Weight: kgs | |
| Nose: | | Throat: | | Heart: | |
| Abdomen: | | Gland: | | | |
| Lungs (X-ray/Tine Test): | | | | | |
| Nutritional status: | | | | | |
| Allergic History: | | | | | |
| Medication: | | | | | |
| Urinalysis | | | | | |
| Sp.Gr: | | PH: | | Albumin: | |
| Sugar: | | RBC: /Hpf | | WBC: /Hpf | |
| Complete Blood Count (For student over 12 years) | | | | | |
| Blood Group: | | RH Titer: Positive/Negative | | | |
| Hb: gm % | | Hct: % | | WBC: | |
| Platelet: | | L: M: % | | E: B: % | |
| Please attach a medical note if your child needs special care or to be given first aid care in case of emergency. | | | | | |
| I certify that all the information given above is complete and correct. | | | Hospital stamp and date: | | |
| Physician's full name: | | | | | |
| Signature: | | | | | |

New Student Health Form

We require confirmation for students from **Pre Nursery to Year 13** to complete the following health checks prior to acceptance at Harrow International School Bangkok. **Parents can obtain this health check from the doctor/hospital of their choice.** Please also take your child's vaccination record to the hospital.

1. Medical Examination

Each new student needs to have a complete medical examination – physical examination and laboratory tests – at the time of registration in line with Harrow Bangkok Policy. Please ensure the doctor signs this form and that the hospital/clinic stamp is included.

You will also need to take your child's vaccination record to the hospital (the doctor will check this information and record it on the Student Health Record).

Note: Medical examinations and/or eye checks, dental checks and hearing tests conducted after the February before admission are acceptable.

2. Tine Test or Chest X-Ray

Students are required to have a negative report on either a **tine test** or **chest X-ray** taken within one year of August enrolment.

3. Record of Medical Examination/Parent Consent Form

Each new student is required to submit a completed Record of Medical Examination and the Parent Consent Form to the school nurse. This card is to be renewed at the beginning of each academic year.

Please ensure you inform us of any changes to your contact information (address, email and phone number) so we can contact you in case of a medical emergency.

| Physical Examination Requirements | Under 12 years | Over 12 years |
|--|----------------|---------------|
| 1. Physical examination (doctor's exam, blood pressure, weight, height) | √ | √ |
| 2. Tuberculin test or chest X-ray (Recommended Year 1 onwards) | √ | √ |
| 3. Blood group ABO, Rh | √ | √ |
| 4. Urine examination | √ | √ |
| 5. Dental examination | √ | √ |
| 6. Audiogram | √ | √ |
| 7. Eye examination | √ | √ |
| 8. Complete blood count (CBC) | - | √ |

| RECOMMENDED HOSPITALS | Contact Number |
|--|--|
| You may obtain this Harrow Bangkok health check from the doctor/hospital of your choice. | |
| Bumrungrad Hospital | 02-011 3111, 02-011 5020 (Health Screening Centre 11 th Floor) |
| Mongkutwattana Hospital | 02-574-5000-9 Ext. 8301 |
| Praram 9 Hospital | 063-268-5408 |
| Paolo (Sapankwai) Hospital | 02-271-7000 Ext. 11262 |
| Saint Louis | 02-675-5000 Ext. 51304-7 (Mon-Fri only) |
| ** Samitivej Hospital (Sukhumvit) | 02-022 2222 |
| ** Samitivej Hospital (Srinakarin) | 02-378 9000 |
| Vibhavadi Hospital | 02-561-1111 Ext. 2150 |

**** Please inform the hospital when you book that you are from Harrow Bangkok and they will offer a discounted rate.**