AISM
American International School of Mozambique

AISM HEALTH HISTORY AND CONSENT FORM

(to be submitted annually)

Section 1: This section to be completed by Parent/Guardian

Student's First Name _____ Student's Last Name_____

Grade _____ School Year_____

Date of Birth _____

Mother Name _____ Father Name _____

Cell No _____ Cell No_____

Student Health Concerns

	*YES	NO		*YES	NO		*YES	NO
Allergies (food, medication, other)			Specify:					
Allergies (Seasonal)			Diabetes			Hearing Problems		
ADHD			Drug sensitivities			Joint or bone problems		
Asthma			Epilepsy/Seizures			Kidney / Bladder disorder		
Autoimmune disease			Frequent ear infections			Other		
Back pain			Frequent headaches			Psychological Issues		
Cardiac disorder			Head injury (Concussion)			Skin Disorder		
			Is Emergency treatment or medication to be stored at school?				YES	NO

(For medication required at school, a Medication Authorisation Form must be submitted)

*For all YES answers, describe relevant symptoms and/or treatment:

_____

_____

_____

Does your child wear glasses / contact lenses YES ☐ NO ☐

Does your child have a hearing device YES ☐ NO ☐

Name of Medical Aid Provider and Membership Number _____

I, the undersigned, authorize:

My child to be taken to the nearest hospital in case of an emergency. I shall not hold AISM liable for any expenses, claims, loss or damage that may arise because of such action. YES ☐ NO ☐

For my child's health history to be discussed with other medical personnel, teachers, and staff as is deemed necessary. YES ☐ NO ☐

AISM Health Services to administer non-prescription medication for minor ailments (e.g. Paracetamol, Ibuprofen, lozenges, antiseptic and anti-inflammatory creams and antihistamines) to my child. YES ☐ NO ☐

_____ _____

Date **Parent / Guardian Signature**

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AISM VACCINATION AND FITNESS CERTIFICATION

(one-time submission; re-submissions only required for incomplete vaccine series)

Section 2: This section to be completed by a Health Care Provider

Student's First Name _____ Student's Last Name_____

Date of Birth _____

a.) Vaccine Requirements

VACCINE	**RECORD COMPLETE DATES (month, day, year) OF VACCINE GIVEN**				
DTaP/Td/Tdap	1.	2.	3.	4.	5. (age 10-14)
Polio (IPV, OPV)	1.	2.	3.	4.	
Measles, Mumps, Rubella (MMR)	1.	2.			
Yellow Fever **(For Grade 6 to 12 only)**	1.				

b.) **Fitness Certification (check only <u>one</u> box)**

☐ I certify that the above student has been medically evaluated and is deemed fit to participate in all school and sport-related activity.

OR

☐ I certify that the above student has been medically evaluated and he/she requires further evaluation before clearance for activity is given.

_____ _____ _____

Signature of Licensed Health Care Provider **Print name or stamp** **Date**