

GSIS ENTRANCE HEALTH FORM



GYEONGGI SUWON
INTERNATIONAL SCHOOL

GSIS requires that your child is immunized and receives a comprehensive physical examination before entering GSIS.

The parent completes Part I of the form. The physician completes Part II of the form.

This form must be completed no longer than 6 months before your child's entry into GSIS.

If there are any questions, please contact the Nurse office (031-695-2829, 8am - 3pm).

Part I-1. Student and Family Information

Student's Name		Date of Birth		Sex		Entering Grade					
Last Name_____		_____		Male_____		JK PK K 1 2 3 4 5 6 7 8 9 10 11 12					
First Name_____		Month Day Year		Female_____							
Korean Name_____											
Father's or Legal Guardian's Name:				Cell Phone:		Email:					
Mother's or Legal Guardian's Name:				Cell Phone:		Email:					
Home Address:						Home Phone:					
Emergency Contact Name:		Relationship:		Home Phone:		Cell Phone:					

Part I - 2. Medication Permission

Please check the following list of common medications, which the school nurse may administer to your child as needed at school.

Acetaminophen(Tylenol) - pain and fever relief	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Cough Syrup - for cough	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Ibuprofen(Advil) - pain relief and anti-inflammatory	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Minol Troches(Lozenge) - sore throat relief	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Tylenol cold - for general cold symptoms	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Benadryl - for allergic reactions	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Sudafed(Non-drowsy) - for nasal/sinus congestion	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Pepto-bismol - for stomach indigestion, nausea, and diarrhea	<input type="checkbox"/> Yes / <input type="checkbox"/> No

Part I - 3. Medical History

Allergies (food, medicine, insect, seasonal)	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Hearing Problems	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Heart Disorder	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Epilepsy/Seizure Disorder	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Hepatitis A/B/C	<input type="checkbox"/> Yes / <input type="checkbox"/> No
ADD/ADHD	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Anxiety Disorder	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Skin Problems	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Speech Difficulty	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Gastrointestinal Disorder	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Frequent Nosebleeds	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Other health problem	<input type="checkbox"/> Yes / <input type="checkbox"/> No

- If you have answered **YES** to any of the above or your child has any **additional medical issues**, please explain in detail:

- List any **medication** the student takes on a regular basis:

- Has your child ever had **surgery / hospitalization** in the past? Yes / No
If **YES**, please give date(s) and details:

- If you have answered **YES** to **Allergies**, please describe

Specify Allergies (food, medicine, insect, seasonal or other)	Reaction	Treatment

Part I - 4. Emergency Care Permission

- Permission is hereby given for emergency measures to be taken in case of accident or sudden illness with the understanding that I will be notified as soon as possible.
- I certify that all information given on this form is complete and correct.
- I acknowledge that it is my responsibility to inform the Nurse Office of any changes in my child's health, physical condition, or medical need

Information may be shared with appropriate personnel for health and educational purposes.

Parents/Guardian: Signature _____

Date _____

Part II - 1. Immunization Record

* GSIS follows the Korea CDC immunization schedule. Please help us ensure the student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio, & MMR at age 4-6 and DT/Td/Tdap at age 11-12.

* Please PRINT the exact dates (mm/dd/yr) of vaccinations received.

Type of Vaccine		1 st Dose mm/dd/yr	2 nd Dose mm/dd/yr	3 rd Dose mm/dd/yr	4 th Dose mm/dd/yr	5 th Dose mm/dd/yr
DPT/DTaP: Diphtheria, Tetanus, & Pertussis		2 months	4 months	6 months	15-18 months	4-6 years
		/ /	/ /	/ /	/ /	/ /
DT/Td/Tdap: Tetanus & Diphtheria		11-12 year				
		/ /				
Polio		2 month	4 months	6-18 months	4-6 years	
		/ /	/ /	/ /	/ /	
MMR: Measles, Mumps, & Rubella		12-15 months	4-6 years			
		/ /	/ /			
OR Separated MMR Vaccines	Measles	/ /	/ /			
	Mumps	/ /	/ /			
	Rubella	/ /	/ /			
Hepatitis B		#1	#2	#3		
		/ /	/ /	/ /		
Varicella (Chicken pox) Or Disease History		12-15 months	4-6 years	Disease History		
TB Screening (School Nurse ONLY)						

Hospital Name / Phone Number / Physician Signature (or Stamp)

Date of Verification (mm/dd/yr)

Part II – 2. Comprehensive physical Examination Report

* This page needs to be filled out by a **PHYSICIAN**.

Student's Name: Last _____ First _____ Middle _____ **Date of Birth (mm/dd/yr):** ____/____/____ **Grade:** _____

Height: _____ cm Weight: _____ kg Blood Pressure _____/____ (ONLY for students age 11 and older) Pulse _____

Vision: R _____ L _____ Both _____ Corrective Lens: Yes / No

Please administer the following tests.	Date (mm/dd/yr)	Result
Tuberculosis Skin Test OR Chest X-ray (NOTE: If TB skin test result is positive, chest X-ray is required regardless of previous BCG vaccination)		TB skin test: Chest X-ray:
Hemoglobin (Secondary students only)		
Urinalysis		

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

Physician's Comments:

» **This student is physically able to participate in all physical education and sports activities:** Yes / No

If NO, please explain:

Hospital Name / Phone Number / Physician Signature (or Stamp)	Date of Examination (mm/dd/yr)
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