Student's Name: Grade Applying: Date:

Jakarta Intercultural School

Nurses Office

Pattimura Elementary
Jl. Pattimura Blok I No.2
Kebayoran Baru Jakarta 12110
T: +6221 509 89 555 ext. 30121
www.jisedu.or.id

Pondok Indah Elementary
Jl. Duta Indah III Pondok Indah
Jakarta 12310
T: +6221 509 89 555 ext. 20121

Cilandak Campus
Jl. Terogong Raya No. 33
Jakarta 12430
T: +6221 509 89 555 ext. 11325

Immunization & Medical Clearance Form

Must be completed by a licensed physician no more than 6 months before the expected start date.

IMMUNIZATION RECORD:

Attach a copy of the student's immunization records or fill out the section below.

All students, as a condition for admission, must be current on their childhood immunization schedule. At the minimum this includes Polio, Diphtheria, Pertussis, Measles, Mumps, Rubella and Hepatitis B.

Dear Parent/Guardian,

Getting immunized is important for at least two reasons: to protect yourself and to protect those around you. Vaccines are the best way we have to prevent infectious disease. Therefore, at JIS, we require students to have to following vaccinations:

Required JIS Vaccinations	Date				
DPT, DtaP	2 months ...../...../.....	4 months ...../...../.....	6 months ...../...../.....	15-18 months ...../...../.....	4-6 years ...../...../.....
DT > 7 years	10 years after last DPT need a booster ...../...../.....				
Polio	2 months ...../...../.....	4 months ...../...../.....	6-18 months ...../...../.....	4-6 years ...../...../.....	
Hepatitis B	shortly after birth ...../...../.....	1-2 months ...../...../.....	6-18 months ...../...../.....		
Measles	12-15 months ...../...../.....	4-6 years ...../...../.....			
Mumps	12-15 months ...../...../.....	4-6 years ...../...../.....			
Rubella	12-15 months ...../...../.....	4-6 years ...../...../.....			

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For living in Indonesia we would additionally recommend to get the following vaccinations following CDC (Center of Disease Control and Prevention) advice:

Recommended Vaccinations	Date				
HIB	2 months ...../...../.....	4 months ...../...../.....	6 months ...../...../.....	12-15 months ...../...../.....	
Meningococcal	11-12 years ...../...../.....	Booster (16 years) ...../...../.....			
Hepatitis A	2 shots 6 months apart ...../...../.....				
Typhoid	Typhoid every 2 years ...../...../.....				
Rabies	Day 0 ...../...../.....	Day 7 ...../...../.....	Day 21-28 ...../...../.....		
Japanese Encephalitis	Day 0 ...../...../.....	Day 28 ...../...../.....			
Varicella/ Chickenpox	Children <13 years 2 shots **1.) 12-15 months** ...../...../..... **2.) 4-6 years** ...../...../.....	Children <13 years 2 shots **1.) Day 0** ...../...../..... **2.) Day 28** ...../...../.....			
HPV (Human Papiloma Virus)	2 shots 6-12 months apart ...../...../.....	3 shots in 6 months ...../...../.....			
COVID-19	1st shot ...../...../.....	2nd shot ...../...../.....	3rd shot ...../...../.....		

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PHYSICAL EXAMINATION

	Normal	Abnormal
Eyes	☐	☐
Ears	☐	☐
Nose	☐	☐
Throat	☐	☐
Teeth	☐	☐
Neck	☐	☐
Lung	☐	☐
Heart	☐	☐

	Normal	Abnormal
Abdomen	☐	☐
Posture	☐	☐
Joints	☐	☐
Skin	☐	☐
Neurological	☐	☐
Behavioral	☐	☐
Emotional	☐	☐

Height: Weight:

Blood Pressure: Vision: R L

☐ The student's immunizations for Polio, Diphtheria, Pertussis, Measles, Mumps, Rubella and Hepatitis B are current

Describe findings:

Able to participate in sports? ☐ Yes ☐ No

Restricted from the following activities:

Examination completed by: Signature & Stamp:

Printed Name: Title: Date:

Address

Office Phone Number: Email:

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PARENT SUPPLIED MEDICAL HISTORY AND EMERGENCY CONSENT FORM

Does your child have any present illnesses? ☐ Yes ☐ No

If yes, please describe:

Past history of:

	Yes	Age	Describe
Diabetes			
Epilepsy			
Fainting Spells			
Heart Disorders			
Meningitis			
Scoliosis			
Skin Problems			
Tubercolosis			
Urinary Disorder			
Hospitalizations or Serious injuries			
Other			

1.) Does your child have any known allergies? ☐ Yes ☐ No

2.) If yes: ☐ Drugs ☐ Foods ☐ Bees/ Insects

3.) Reaction: _____

4.) Medication/antihistamine? ☐ Yes ☐ No

5.) Does your child have an epi pen? ☐ Yes ☐ No

6.) Does your child have a history of asthma? ☐ Yes ☐ No

7.) Does he/she carry an inhaler? ☐ Yes ☐ No

8.) Does your child wear glasses or contact lenses? ☐ Yes ☐ No

9.) Does your child have trouble hearing or use a hearing aid? ☐ Yes ☐ No

10.) Is your child on daily medication? ☐ Yes ☐ No

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Please list the name of the medications and the time frequency required:

Medications	Time

Is there any health condition that the school should be aware of or any limitations on your child's physical activity?

Student may not receive medication unless written permission is signed by a parent or guardian. Parents of Elementary students will be contacted before any medication is given.

By signing below:

1. I attest that all the above information is accurate.
2. I hereby give permission to the school to administer the following medications to my child if deemed necessary by the school nurse: Tylenol - Panadol - Ibuprofen - Charcoal - Antacid - Cold Medicine (Please cross out (x) any medication NOT to be given to your child).
3. I hereby give permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified.

Parent signature: Date: