International School of Kenya

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Place current passport photo here

ISK is accredited by the Council of International Schools and by the Middle States Association of Schools and Colleges

HEALTH OFFICE: STUDENT PERSONAL INFORMATION

PART I: HEALTH ASSESSMENT (To be completed by Parent/Guardian)

Student's full name ____
Last *First* *Middle*

Male___Female___ Grade___ Date of Birth ___________________________
(MM/DD/YYYY)

Parent (Father) Name:	Parent (Father) Mobile: Email:
Parent (Mother) Name:	Parent (Mother) Mobile: Email:
Family physician in Nairobi:	Telephone:

EMERGENCY CONTACT INFORMATION

Please name an adult in Nairobi, other than the parents, who can be contacted in case of an EMERGENCY.	
Name:	Relationship:
Physical Address:	
Mobile:	Email address:

Is there any serious health condition that the school should be aware of which could require **EMERGENCY ACTION** or place any limitations on your child's physical activity (For examples: seizures, asthma, allergy, bleeding disorders, diabetes, heart problems, etc.)? If yes, please explain:

Is your child on daily or long-term medication? No____ Yes____
If yes, medication(s): Dosage: Time/Frequency required:

Is there any **medical reason** your child is **not allowed** to participate in contact sports, general sports, or swimming? No____ Yes____
If yes, explain:

Does your child have a past history of or any current medical conditions that might need special attention during school, sports or trips? No____ Yes____
If yes, please explain:

Has your child received all childhood vaccinations? No____ Yes___
Please attach immunization records

Is your child covered by health insurance? No____ Yes_____ (Please note ISK is not a health provider)

Insurance provider name: ____________________Policy #: _______________Phone number: _____________

Please add any additional information on the form provided and/or attach any reports that are relevant.

Does your child have a past history of or is he/she currently affected by:	Y	N	If you answer yes to any of the questions, please provide detailed information below including age of onset.
Allergy (ies) **If yes list SPECIFIC allergy(ies) (e.g. drug, food, bees/insects, dust, pollen):**			
Altitude sickness /Acute mountain sickness			
Asthma **If yes list type of inhaler use: How often:**			
Attention Deficit Disorder/ADHD			
Back pain			
Cerebral Palsy			
Diabetes **If yes diet control or insulin management**			
Ear problem/Deafness			
Enlarged Liver or Spleen			
Epilepsy/Seizures/Convulsions			
Head Injury			
Heart disorder/infection/chest pain:			
Joint or Bone problem (e.g. Fracture, dislocation, painful joint etc.)			
Kidney or Bladder disorder/infection			
Meningitis			
Mental health problems (e.g. anxiety, depression, panic attacks etc)			
Nutritional concerns **Type of DIET requirement/restriction:**			
Respiratory (lung) disorder/infection			
Sickle Cell Anemia			
Heart or Lung Disorder/Infection			
Serious Muscle Injury or Rupture			
Scoliosis			
Sickle Cell Anemia			
Skin problem (e.g. eczema)			
Speech/Language problem			
Surgery (ies) **If yes state type and year:**			
Weak or ill when exposed to high temperatures			
Wear glasses/contact lens			
Wear dental braces			

Before every school trip outside Nairobi, parents/guardians should get advice from their physician concerning malaria prevention/relevant vaccinations.

1. I give my permission for confidential and discreet use of the medical evaluation completed by the physician to meet my child's health and educational needs at school.
2. I give my permission to administer treatment and/or over-the-counter medication at school to my child if deemed necessary by the school medical staff.
3. I give my permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified.
4. I will keep the health office informed of any change in my child's health and/or medication at all times.
5. List any medical treatments you **DO NOT want your child to receive:**

Parent Signature ____ Date (MM/DD/YYYY) __________________

PART II: Health Evaluation (To be completed by Physician/Nurse Practitioner)
Student´s Full Name ____ *Last* *First* *Middle*

Date:	Height:	Weight:	Blood Pressure:	Pulse:	Blood Type (Must be provided)
Vision Acuity Test		**Date:**	**L R**		**Glasses: Yes ___ No ____**
Hearing Test		**Date:**	**L R**		
Comments:					

COMPULSORY TB Screening Requirement ***NOTE: a previous BCG vaccine does not exclude a child from this test.***	**Date test performed:**
Skin Test: Type	
Results: Positive ______ Negative _______	**Follow up for positive result:** ***Note: Please attach copy of PPD and/or x-ray result.***

Are there any significant findings in the following areas:	***Normal***	***Abnormal***		***Normal***	***Abnormal***
ENT			Gastrointestinal System		
Lymphatic Glands			Central Nervous System		
Circulatory System			Muscular Skeletal System		
Respiratory System			Skin		

Describe findings:

____

____

Comments: ____

____

Restriction on any type of sports or physical activity in school: _______________________

____

Recommendations for referral and treatment for any relevant areas:

____

____

The student named above has had a completed history and physical examination at my office and has no evident health problem except as noted above.

Physician/Nurse Practitioner Name: ____

(Print clearly)

Signature: ______________________ *Date:* ___________ *Contact:* ___________________________

Medical Facility Stamp: