



## HEALTH OFFICE: STUDENT PERSONAL INFORMATION

Place current  
passport photo  
here

### 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. If a parent cannot be reached in an emergency, I agree that this person has in loco parentis authorization to make decisions on our behalf in consultation with school personnel; this person shall retain this authorization until I revoke or change it in writing or until my child leaves the school.*

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 participation in physical activity, contact sports, general sports or swimming (Seizures, Asthma, Allergy/ies, Bleeding disorders, Diabetes Heart disease, etc.)  
 If yes, please explain

Is your child on daily or long-term medication? No \_\_\_ Yes \_\_\_

Would they need the medicine to be administered at school at any one time No \_\_\_ Yes \_\_\_

If Yes, Medication \_\_\_ Dosage \_\_\_ Time/Frequency required \_\_\_

Would you be comfortable if this information were to be shared with Divisional Grade Level Leaders?

**No** \_\_\_\_\_ **Yes** \_\_\_\_\_

If **No**, Please Click [HERE](#) to Download and Complete the Confidentiality Form privy to Health Clinician.

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:** \_\_\_\_\_

<b>Please add any additional information on the form provided and/or attach any reports that are relevant.</b>			
<b>Has your child had a history of or presently has any of the following:</b>	<b>Y</b>	<b>N</b>	<b>If you answer yes to any of the questions, please provide detailed information</b>
<b>Wears glasses/contact lenses</b>			
<b>Hearing difficulties</b>			
<b>Wears dental braces</b>			
<b>Allergy (ies)</b> If yes SPECIFY ( e.g. drug, food, bees/insects, dust, pollen): Skin problem (e.g. eczema)			
<b>Asthma</b> If yes state type of inhaler/medication used:			
<b>Diabetes</b> <b>IDDM</b> <b>NIDDM</b>  (Please tick)			
<b>Epilepsy/Seizures/Convulsions</b>			
<b>History of Speech/Language delay or difficulty</b>			
<b>AD(H)D or other behavioral concerns (state the medication)</b>			
<b>Autism Spectrum Disorder/Aspergers</b>			
<b>Cerebral Palsy</b>			
<b>Sickle Cell Anemia or any other anaemia</b>			
<b>Scoliosis</b>			
<b>Social emotional &amp; psychological concerns - state the medication</b>			
<b>Heart problems</b>			
<b>Bleeding disorders e.g. (Hemophilia A/B, Von Willebrand disease)</b>			
<b>Altitude sickness (from past experience)</b> <b>Surgery (ies)</b>			
If yes state what surgery and year:			
<b>Nutritional concerns</b> <b>Type of DIET requirement/restriction:</b>			

**Before every school trip outside Nairobi, parents/guardians should get advice from their physician concerning malaria prophylaxis/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 Health Office Medical Staff.
  3. I give my permission for emergency measures to be initiated in any emergency 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 INTERVENTIONS THAT 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)

**Comments:**

Has BCG vaccination been given (at birth or later)?

**YES:** \_\_\_\_ **NO:** \_\_\_\_

**If NO,** please note that there is a high incidence of Tuberculosis in Africa/Asia/South America

**Because Kenya has a high incidence of TB, ISK requires proof of no active TB every 2 years.**

**Please provide documentation of ONE of the following:**

Mantoux/PPD Skin Test      Date: \_\_\_\_      Result \_\_\_\_mm

Chest x-ray      Date: \_\_\_\_      Positive \_\_\_\_      Negative \_\_\_\_

Sputum Gene Xpert      Date: \_\_\_\_      Positive \_\_\_\_      Negative \_\_\_\_

Are there any significant findings in the following areas:					
Central Nervous System			Gastrointestinal System		
Cardio Vascular System			Genito Urinary System		
Lymphatic system			Muscular Skeletal System		
Respiratory System			Skin		

**Describe findings:**

\_\_\_\_\_

Recommendations for referral and treatment for any relevant areas:

\_\_\_\_\_

**Physician/Nurse Practitioner Name:**

\_\_\_\_\_

*(Print clearly)*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Contact:** \_\_\_\_\_

**Medical Facility Stamp:**