International School of Kenya

Empowering students to create solutions for tomorrow's challenges

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 (Mother) Name:	Parent (Father) Mobile: Email: 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:** _____

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

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

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 <u>DO NOT WANT YOUR CHILD TO RECEIVE</u>**

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: