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:
If yes, please explain:

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

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			
History of Speech/Language delay or difficulty			
AD(H)D or other behavioural 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			
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 **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:					

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

Tick if BCG was given

At birth: <7 years of age (date):

Mantoux done yes: no:

If yes 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:					
Central Nervous System			Gastrointestinal System		
Cardio Vascular System			Genito Urinary System		
Lymphatic system			Muscular Skeletal System		
Respiratory System			Skin		

Describe findings:
_____

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

Recommendations for referral and treatment for any relevant areas:
_____

Physician/Nurse Practitioner Name:

_____
(Print clearly)

Signature: _____ ***Date:*** _____ ***Contact:*** _____

Medical Facility Stamp: