

MEDICAL INFORMATION and HEALTH HISTORY SY 2010-2011

Name of Student: _____

Student Date of Birth: _____

Name of parent filling out form: _____

Date form filled out: _____

Allergies? No Yes

To what: _____

Reaction: _____

Drug Allergies? No Yes

To what: _____

Reaction: _____

Asthma No Yes

Does the student carry an inhaler? No Yes

Is the student on regular medication? No Yes

Name of medication/frequency: _____

Does the student take any medication during school hours? No Yes

Name of medication/frequency: _____

Any other health conditions that the school should be aware of, e.g. diabetes, epilepsy, etc? :

Does the student have any present illness? : _____

Past History: If Yes, give age and describe below.

	No	Yes	Age		No	Yes	Age
Skin Problem				Asthma			
Diabetes				Heart Disorder			
Meningitis				Urinary Disorder			
Tuberculosis				Epilepsy			
Fainting Spells				Scoliosis			
ADD/ADHD				Other Illness			

Describe: _____

Hospitalizations, Serious Injuries: Why?/When? _____

Name of Student: _____

Eye glasses or contact lens: No Yes Eye or vision problems, describe: _____

Hearing problem(s), multiple ear infections: No Yes Describe: _____

IMMUNIZATION RECORD Please complete schedule below. Include dates for childhood vaccinations.

The tests/immunizations below are recommended according to school policy.

<i>TYPE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>
Anti TB-BCG Vacc.: (within 5 years) OR					
The following Tests: Mantoux Test within 1 year Positive <input type="checkbox"/> Negative <input type="checkbox"/> (tick box)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the above positive require: Chest xray Positive <input type="checkbox"/> Negative <input type="checkbox"/>					

Please complete the following schedule including dates

<i>TYPE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>	<i>DATE</i>
DPT/DT					
Polio					
Measles					
Mumps					
Rubella					
Hep A					
*Hep B					
* Meningitis					
*Yellow fever					
*Typhoid					
*Tetanus					

* Recommended vaccinations for Sudan.

AUTHORIZATION

I give consent for my child to receive the following:

- 1. Minor first aid (at school) YES NO
- 2. Emergency care (at school) YES NO
- 3. Emergency care at Doctor’s Clinic YES NO
- 4. Oral non-prescription medication YES NO
- 5. Malaria test kit YES NO

• NOTE: If “NO” to 1,2, and/or 3 above, you must provide alternate emergency care instructions to be on file in the school health office.

ALTERNATE EMERGENCY CARE DETAILS

Hospital name, number, and address for emergency care:

Permission is hereby given for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

I certify that all information given on this card is complete and correct.

I acknowledge that it is my responsibility to inform KAS of any changes in my child’s health, physical condition, or medical needs.

I agree to allow the school to transport my child to indicated hospital in the event my child needs immediate emergency care.

Student name: _____

Parent name: _____

Parent Signature: _____ Date: _____

To ensure continuity of health care, could you also please provide the name, number, and address of your child’s family doctor and/or specialist.

Name: _____

Number: _____

Address: _____