SURABAYA INTERCULTURAL SCHOOL

HEALTH & EMERGENCY FORM

This form is to be completed in full and signed by a parent and a doctor before a student attends classes or participates in physical education and/or sports activities. SIS reserve the right to withhold a student from classes until this form is completed and submitted along with other required SIS forms. It is the responsibility of parents to notify the school nurse in writing of any changes in this form.

PHOTO
3 X 4 CM

1. CHILD'S PERSONAL DATA

CHILD'S FULL NAME (Passport Name) : FAMILY NAME FIRST NAME MIDDLE NAME

BIRTH DATE : MM/DD/YY ☐ MALE ☐ FEMALE

FATHER'S NAME : _____ MOTHER'S NAME : _____

BROTHER'S / SISTER'S ATTENDING SIS : 1. _____ 2. _____ 3. _____ 4. _____

FATHER'S HP : _____ MOTHER'S HP : _____

HOME PHONE : _____ OFFICE PHONE : _____

PERSON TO CONTACT IN AN EMERGENCY : 1. _____ PHONE : _____ 2. _____ PHONE : _____

FAMILY DOCTOR : _____ CLINIC PHONE : _____

CLINIC ADDRESS : _____

FAX : _____ MOBILE PHONE : _____

PLEASE NOTE : *Where no Doctor's name is given, the school Doctor will be contacted. In his or her absence When neither parents nor alternatives can be Contacted, the School will use its best judgment in an emergency.*

DRUG AND/OR FOOD ALLERGIES :

_____

PERMISSION TO ADMINISTER PANADOL/TYLENOL :

☐ YES ☐ NO

2. IMUNIZATION HISTORY

	FILL IN THE DATES IMMUNIZATION GIVEN					REMARK
BCG						
DPT (Diphtheria, Pertussis, Tetanus)						
POLIO						
MEASLES						
MMR (Measles, Mumps, Rubella)						
HEPATITIS B						
HEPATITIS A						
TYPHOID						
HIB						
CHICKEN POX						
OTHERS						

3. PARENTAL PERMISSION AND CERTIFICATION

Permission in hereby given for emergency measures to be initiated in case of an accident or sudden illness, with the understanding that i will be notified.

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS COMPLETE AND CORRECT.

PARENT'S NAME : _____ SIGNATURE : _____ DATE : MM/DD/YY

4. PHYSICAL EXAMINATION REPORT

This part to be completed by a licensed Doctor.

DATE OF PHYSICAL EXAMINATION:

HEIGHT : _____ WEIGHT : _____ BLOOD TYPE : _____ (IF KNOWN)

B/P : _____ HEART RATE : _____

VISION	RIGHT	LEFT
UNCORRECTED	/	/
CORRECTED	/	/

	HEAD	ABDOMEN	SPINE	EXTREMITES
NORMAL				
ABNORMAL				
REMARKS				

TUBERCULOSIS SCREENING :

Scholl policy regarding tuberculosis screening at SIS states that students new to SIS will provide the school with the vaccination history (BCG) and the results of recent tuberculin test(s), if any.

If the child received a BCG vaccination in the past and has a positive tuberculin test, there is no need for annual follow-up tuberculin testing.

If the child did not receive a BCG vaccination, annual tuberculin testing is strongly advised by SIS.

TB SKIN TEST TEST TYPE : _____ DATE : MM/DD/YY RESULT : _____

The following health conditions can be of concern. Please mark with a check (3) any that apply and comment on the checked item(s) below:

- ☐ ALLERGIES
- ☐ ASTHMA
- ☐ CONVULSION/EPILEPSY
- ☐ CONGENITAL ANOMALIES
- ☐ DIABETES
- ☐ EAR INFECTIONS
- ☐ HEARING DIFFICULTIES
- ☐ FREQUENT HEADACHES
- ☐ HEART PROBLEMS
- ☐ POST OPERATIONS
- ☐ ORTHOPEDIC PROBLEMS
- ☐ MENSTRUAL PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ SKIN PROBLEMS
- ☐ VISUAL PROBLEMS
- ☐ KIDNEY/URINARY INFECTIONS

COMMENTS : _____

DO ANY OF THE ABOVE ITEMS PREVENT PARTICIPATION IN PHYSICAL EDUCATION/SPORTS ACTIVITIES ? ☐ YES ☐ NO

Please describe limitations, if any : _____

If the student is currently on medication, please describe type of medication, dosage and purpose:

_____

PLEASE NOTE : *All prescription medications need a written note from the parent which must be on file with the school nurse. Medications need to be in the original pharmacy/physician containers and marked with the student's name, name of drug, dosage, schedule, and instructions.*

DOCTOR'S NAME : _____ SIGNATURE : _____ DATE : MM/DD/YY

DOCTOR'S STAMP : _____