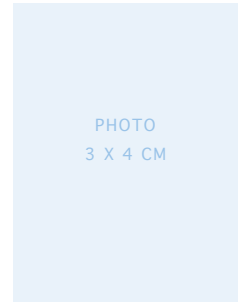


This form is to be completed in full and signed by a parent and a doctor before a student attends classes or participates in physical education and/or sports activities. SIS reserve the right to withhold a student from classes until this form is completed and submitted along with other required SIS forms.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



1. CHILD'S PERSONAL DATA

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

BIRTH DATE : _____ MALE FEMALE
MM/DD/YY

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 is 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 : _____

B/P : _____ HEART RATE : _____ (IF KNOWN)

VISION	RIGHT	LEFT		HEAD	ABDOMEN	SPINE	EXTREMITES
			NORMAL				
UNCORRECTED	/	/	ABNORMAL				
CORRECTED	/	/	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:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> CONVULSION/EPILEPSY | <input type="checkbox"/> CONGENITAL ANOMALIES |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> HEARING DIFFICULTIES | <input type="checkbox"/> FREQUENT HEADACHES |
| <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> POST OPERATIONS | <input type="checkbox"/> ORTHOPEDIC PROBLEMS | <input type="checkbox"/> MENSTRUAL PROBLEMS |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> SKIN PROBLEMS | <input type="checkbox"/> VISUAL PROBLEMS | <input type="checkbox"/> 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 : _____