Student Medical Form

Student Name: ______________________ Age: ______________________

Date of Birth: ______________________ Student Grade: ______________________

Insurance Information

My child is covered by (insurance provider): ______________________

Insurance Policy number: ______________________ Expiration Date: ______________________

Student Health History

Please answer the following questions regarding the health history of your child. All information will be kept confidential.

For Yes answers, please list any treatment or medication. Please attach additional documentation as needed.

CONDITION	YES	NO	TREATMENT / MEDICATION
ADD / ADHD			
Asthma			
Bedwetting			
Bone/Skeletal Problems			
Chicken Pox			
Diabetes			
Dizzy Spells			
Eczema			
Epilepsy			
Heart Disease			
Migraine			
Sleepwalking			
Special Dietary Considerations			
Travel/Motion Sickness			

Please inform us of any other emotional, behavioral, or psychiatric problems that the school should know:

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Has your child been vaccinated against the following?
PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS FOR VERIFICATION.

VACCINE	YES	NO	DATE	VACCINE	YES	NO	DATE
Polio (oral or IPV)				Tuberculosis / TB (PPD or vaccine)			
Diptheria/Pertussis/Tetanus (DPT)				Measles/Mumps/Rubella (MMR)			
Hepatitis A				Hepatitis B			
Varicella (Chicken Pox)				Japanese Encephalitis			

Does your child have any known allergies to:

For Yes answers, please indicate the type of reaction (i.e. hives, swelling, impaired breathing) and/or treatment.

ALLERGY	YES	NO	REACTION/TREATMENT
Food (specify)			
Insect Sting (specify)			
Drug (specify)			
Other (specify)			

Has your child been prescribed an EpiPen? Yes ______ No ______

Does your child have any impairment with the following? If yes, please specify condition and corrective devices (i.e. eyeglasses, hearing aid)

IMPAIRMENT	YES	NO	CONDITION / CORRECTIVE DEVICE / SUPPORT
Hearing			
Speech			
Vision/Eyesight			

Does your child take any medication on a regular basis? If so, please give full details:

MEDICATION / CONDITION	DOSAGE	FREQUENCY (DAILY,ETC)

Should your child complain of minor pain or other problem while at school, the School Nurse **will** administer mild over the counter medications such as acetaminophen / panadol, ibuprofen (not aspirin), antacid tablets (for stomach), cough or sore throat lozenge/syrup, Loratadine (for allergies) or topical ointment for rashes, etc.

Please sign here if you DO NOT want your child to take over the counter medications in school：

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In case of emergency, we will try to reach you, and then transport your child to the nearest full service medical facility, International SOS.

Family Doctor (in Beijing)：______________________ Telephone：______________________________

I verify that the information provided above is accurate. If my child's health status changes, I will communicate those changes to the school.

______________________________ ______________________________ ______________________

SIGNATURE **RELATIONSHIP TO CHILD** **DATE**