



Surabaya International School HEALTH & EMERGENCY FORM

Photo

3 x 4 cm

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 reserves 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.

CHILD'S PERSONAL DATA

FULL NAME: _____
(Family Name) (First) (Middle)

BIRTH DATE: _____ M F
(D / M / Y)

FATHER'S NAME: _____

FAMILY DOCTOR: _____

MOTHER'S NAME: _____

CLINIC ADDRESS: _____

BROTHERS/SISTERS ATTENDING SIS:

1. _____
2. _____
3. _____

CLINIC TEL: _____ FAX: _____

HOME ADDRESS: _____

PAGER #: _____

FATHER'S H/P: _____

H/P: _____

MOTHER'S H/P: _____

HOME TEL: _____

OFFICE TEL: _____

PERSONS TO CONTACT IN AN EMERGENCY:

1. _____ TEL: _____
2. _____ TEL: _____

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

IMMUNIZATION HISTORY

Fill in the dates immunization given

Remarks

1.	BCG						
2.	DPT (Diphtheria, Pertussis, Tetanus)						
3.	Polio						
4.	Measles						
5.	MMR (Measles, Mumps, Rubella)						
6.	Hepatitis B						
7.	Hepatitis A						
8.	Typhoid						
9.	HIB						
10.	Chicken Pox						
11.	Others						

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: _____

PHYSICAL EXAMINATION REPORT

This part is to be completed by a licensed doctor.

DATE OF PHYSICAL EXAMINATION: _____

HEIGHT: _____

WEIGHT: _____

BLOOD TYPE: _____

B / P: _____

HEART RATE: _____

(if known)

VISION	Right	Left
Uncorrected	/	/
Corrected	/	/

	HEAD	ABDOMEN	SPINE	EXTREMITIES
Normal				
Abnormal				
Remarks				

TUBERCULOSIS SCREENING:

- School 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 _____ Result _____

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Congenital anomalies | <input type="checkbox"/> Convulsion/epilepsy |
| <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"/> Menstrual problems | <input type="checkbox"/> Orthopedic problems | <input type="checkbox"/> Post operations |
| <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: _____

DOCTOR'S STAMP: _____