



Photo

Student Health Form

| | |
|-------------|--|
| School Year | |
| Grade | |

Student Information

Student's name: _____
 (as it appears in passport) First Name Middle Name Family Name

Student's Preferred (Nickname) Name: _____

Gender: (M/F) _____ Date of Birth: _____
 Day Month Year

Blood Group _____ Rh Factor _____ Nationality _____
 (Negative/Positive)

Father's Name: _____ Cell Phone: _____

Mother's Name: _____ Cell Phone: _____

Home Address in Thailand: _____

Telephone: _____

Emergencies: Please name another person (other than parents and guardian) who we can contact locally.

1. Contact person: _____ Home: _____ Cell Phone: _____

2. Contact person: _____ Home: _____ Cell Phone: _____

Health History

The following information is strictly confidential and will be shared only by the school staff as required to ensure the well-being of your child and the school population.

Please indicate (yes/no) if your child has a problem with any of the following:

| | |
|---|--|
| Asthma, wheezing, chronic cough or other breathing difficulties | Epilepsy, seizures, convulsions, or unexplained losses of consciousness |
| Orthopedic or back problems; or any condition which impairs full movement | Allergies (e.g. to pollen, dust, insect bites, foods, chemicals, drugs etc.) |
| Diarrhea or stomach problems | Life threatening allergic reactions |
| Frequent headaches, migraines | Sleeping difficulties |
| Congenital heart, cardio vascular problem | Emotional problems |
| Visual problems (squints, glasses, color blindness, itchy or red eyes) | Ear problems (e.g. deafness, tinnitus, infections, aches or 'swimmers ear') |
| Abnormal bleeding (haemophilia, thalassemia) | Communicable diseases |
| Dietary restrictions (religious/medical) | Tropical diseases |
| Physical disability (e.g. speech, sight, hearing or movement) | Menstrual Issues |
| Urinary infections | Diabetes |
| Thyroid problems | Other |

***Please give additional information if you have indicated "yes" to any of the above:** _____

Does your child have any allergies (to medication, food, etc...) that you are aware of?

Yes No Please specify known allergies: _____

Does your child have any illness or condition that the school should be aware of?

Yes No If so, please state: _____

Does your child receive any medication or medical treatment, either regular or occasionally?

Yes No If so, please indicate: _____

Has your child even been hospitalized for any reason?

Yes No If so, for what reason? _____

Does your child have any limitation for Physical Education?

Yes No If so, please explain: _____

Immunization History

Immunization record must be submitted within two months after initial enrollment date.

Please fill in the dates that immunizations were given.

| Vaccine | 1 st dose (dd/mm/yy) | 2 nd dose (dd/mm/yy) | 3 rd dose (dd/mm/yy) | 1 st booster (dd/mm/yy) | 2 nd booster (dd/mm/yy) | Remarks |
|--|------------------------------------|------------------------------------|------------------------------------|---------------------------------------|---------------------------------------|---------|
| Hepatitis B | | | | | | |
| DPT/DT (Diphtheria/Pertussis/Tetanus) | | | | | | |
| Polio | | | | | | |
| MMR (Measles/Mumps/Rubella) | | | | | | |
| JE (Japanese Encephalitis) | | | | | | |
| HIB (Haemophilus Influenza type B) | | | | | | |
| Hepatitis A | | | | | | |
| Chicken pox | | | | | | |
| Influenza | | | | | | |
| Typhoid | | | | | | |
| Other | | | | | | |
| | | | | | | |

Emergency Treatment Authorization: In the event of an emergency when immediate observation or treatment is deemed necessary by the school nurse/administration, I authorize the school to send my child to the medical facility most readily accessible.

Permission to administer Panadol/Tylenol (Acetaminophen)

Yes No

Parent's Signature _____ **Date** _____

It is the responsibility of the parents/guardian to notify the school nurse in writing of any changes to the information given in this form e.g. changes of address, telephone number, physical condition or medications.