**NAME OF STUDENT: D.O.B.: HOMEROOM/GRADE:**

# PART 1: PARENT/GUARDIAN AUTHORIZATION

I request medication(s) be given during school hours as ordered by my child’s physician. I also request the medication(s) be given to the ﬁeld trips, as prescribed. I will notify the school of any change in the medication(s).

I give permission for the medications to be given by the school personnel as delegated, trained, and supervised by the school nurse.

I give permission for the school nurse to communicate, as needed, with school staﬀ about my child’s medical conditions(s) and the treatment prescribed. I give permission to S.I.S. to release appropriate medical information to the hospital in case of emergency.

# PART 2: EMERGENCY CARE PERMISSION

Permission is hereby given for emergency measures to be taken in case of accident or sudden illness with the understating that I will be notiﬁed as soon as possible. I acknowledge that it is my responsibility to inform Seoul International School Health Oﬃce of any changes in my child’s health, physical condition, or medical needs

**PARENT/GUARDIAN SIGNATURE: Date:**

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

|  |
| --- |
| **STUDENT INFORMATION** |
| STUDENT’S NAME (Last, First): | DATE OF BIRTH (MM/DD/YYYY): | BLOOD TYPE: | SEX: | HOMEROOM (GRADE): |
|  |  |  | Male ( ) Female ( ) |  |
| Father’s Name (Last, First): | Cell #: | Mother’s Name (Last, First): | Cell #: |
|  |  |  |  |
| Home Address: | Home Phone #: | Email Address: |
|  |  |  |
| **Emergency Contact (Other than parents):**Name: (Relation: ) Contact number:  |
| **PAST OR PRESENT MEDICAL HISTORY** |
| **Does the child/student have a past or present medical history of the following?** |
| ADD/ADHD |  Y  N | Epilepsy/Seizure Disorder |  Y  N | Hearing Problems |  Y  N | Skin Problems |  Y  N |
| Anxiety Disorder |  Y  N | Frequent Headaches |  Y  N | Heart Disorder |  Y  N | Speech Diﬃculty |  Y  N |
| Chicken Pox |  Y  N | Frequent Nosebleeds |  Y  N | Hepatitis A/B/C |  Y  N | Vision Problems |  Y  N |
| Diabetes |  Y  N | Gastrointestinal Disorder |  Y  N | Scoliosis |  Y  N | *Others:*  |  Y  N |
| **If you have checked on any of the above medical history, please explain in detail:** |
|  |
| **Does your child have allergies?**  **Y**  **N** |
| ***If YES,*** student is allergic to: |  |
| Reactions the student may have: |  |
| Treatments the student may need after exposure: |  |
| **Does your child have asthma?**  **Y**  **N** |
| ***If YES,*** does the student need an inhaler?  Y  N |  Y  N |
| If the student needs an inhaler, please indicate if the inhaler will: |  remain with the student or  be provided to the Health Oﬃce for emergency use. |
| **If your child have other signiﬁcant health conditions that may require emergency medical care at school, child care, ﬁeld trip or sports activity, please explain in detail:** |
|  |

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

|  |
| --- |
| **STUDENT INFORMATION** |
| STUDENT’S NAME (Last, First): | DATE OF BIRTH (MM/DD/YYYY): | BLOOD TYPE: | SEX: | HOMEROOM (GRADE): |
|  |  |  | Male ( ) Female |  |
| **CURRENT MEDICATION STATUS** |
| **Medication Permission:** Please check the following list of common medications which Health Oﬃce may administer to your child as needed at school |
| Acetaminophen (Tylenol) - pain and fever relief |  Y  N | Hexamedine/Tantum spray for sore throat |  Y  N |
| Ibuprofen (Advil) - pain relief and anti-inﬂammatory |  Y  N | Cegaton Troche - For sore throat, stomatitis |  Y  N |
| Zyrtec (tablet) - for allergy (Nasal/Sinus Congestion) |  Y  N | Festal — for stomach indigestion |  Y  N |
| **Please list any medication the student takes on a regular basis:** |
|  |
| **IMMUNIZATION RECORD (DATES: MM/DD/YYYY)** |
| **DT aP** | **OPV / IPV** | **MMR** | **Chicken pox** | **TB Skin Test/Result** | **Tdap** | **HepB** |
| **1.** | **1.** | **1.** | **1.** |  |  | **1.** |
| **2.** | **2,** | **2.** | **2.** |  |  | **2.** |
| **3.** | **3.** |  |  |  |  | **3.** |
| **4.** | **4.** |  |  |  |  |  |
| **5.** |  |  |  |  |  |  |
| **IMMUNIZATION GUIDE AND REQUIREMENTS** | Students who have lost records, must have one OPV booster, one DTaP \*(if under 6 years of age) or Td (if under 18 years of age) booster, and one MMR booster along with annual TB Skin test. Complete record with appropriate immunizations. |
|  | **2 mo** | **4 mo** | **6 mo** | **15 mo** | **18 mo** | **4-6 yr** | **11-18 yr** |
| **DTap/Td** | **#1** | **#2** | **#3** | **#4** | **#5** | **Td/Tdap** |
| **OPV/IPV** | **#1** | **#2** | **#3** | **#4** |  |
| **MMR** |  |  |  | **#1** |  | **#2** |  | ***\*It is parental responsibility to update medical records.*** |
| **Chicken pox** |  |  |  | **#1** | **#2** |  |
| **T.B. Skin Test/Result** | **All students enrolled at Seoul International School are required to have PPD skin test OR chest X-ray every 2 years.** | ***(Pease read page 1-3 and then sign) Signature / date*** |

# PHYSICIAN’S EXAMINATION

**(MEDICAL EXAM MUST BE CURRENT – WITHIN 12 MONTHS OF ENTRY DATE)**

|  |  |  |
| --- | --- | --- |
| Required tests | Date (MM/DD/YY) | Result |
| TUBERCULIN SKIN TESTor Chest X-ray |  |  |
| HEMOGLOBIN |  |  |
| URINALYSIS |  |  |

Name (Last, First) Grade Date of Birth (MM/DD/YY) Sibling at SIS (name/grade)

(If TB skin test result is positive, chest X-ray is required regardless of previous BCG vaccination.)

Height cm

Weight Kg

Pulse

Vision R: L: Both

Blood Pressure / Corrective Lens □ YES / □ NO (Blood Pressure only for students age 11 and older)

## (O) Normal (X) Abnormal (Comment : Specify consultation requested)

|  |  |  |  |
| --- | --- | --- | --- |
| Ears/Hearing |  | Musculoskeletal |  |
| Nose |  | Spine |  |
| Mouth |  | Skin |  |
| Throat |  | Neurological |  |
| Neck |  | Nutritional |  |
| Heart |  | Emotional / Psychological |  |
| Lungs |  | Behavior |  |
| Abdomen |  | Speech |  |
| Physician’s Comments : |

Please list any medication the student takes on a regular basis.

Note : A separate medical form is required for all medication and treatment to be administered at school.

|  |  |  |
| --- | --- | --- |
| Name of Medication | Purpose | Dose/Times |
|  |  |  |

This student is physically able to participate in all physical education and sports activities : □ YES / □ NO

|  |  |
| --- | --- |
| Physician’s Name  | Signature  |
| Hospital | Date |

If NO, Please explain :

SIS requires evidence of immunization for the following (MM/DD/YY): I have seen evidence that these have been administered.

YES NO

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DT&P #1  | OPV/IPV | #1  | MMR | #1  |
| #2  |  | #2  |  | #2  |
| #3  |  | #3  | HepB | #1  |
| #4  |  | #4  |  | #2  |
| #5  |  |  |  | #3  |
|  | Varicella | #1  | Td/ | 11-12 years |
|  |  | #2  | Tdap | #1  |

\* Please print the exact date (MM/DD/YY) of vaccinations received.

NOTE TO THE PHYSICIAN : Please be strict on immunization. Students who have lost records must have the OPV booster, one DTap or Td (if between ages 11 and 18) booster, and one MMR booster along with the annual Tuberculin Skin Test. Please administer appropriate immunization for incomplete records.

Thank you.