STUDENT HEALTH FORM

If you are a new student enrolling at AISC, please attach a copy of the immunization records & proof of physical exam in the last 12 months & submit the complete form to: Sanja Ilic, Admissions Director. Returning students, please return the Student Health Form and the Physical Examination Form to the Health Office.

Name of Student______________________________ **Birth Date** ___________________ **Sex**_____
(MM/DD/YY)

Grade ______________ **Entrance Date**___________________
(MM/DD/YY)

	FATHER	**MOTHER**
Name :		
Home address :		
Home Telephone:		
Mobile:		
Office Address:		
Work Telephone:		

Siblings in the School (names and grades)____

Emergency contacts in Chennai: ____

Emergency Contact's Phone: ____

Doctor's Name: ____

Doctor's Phone: ____

Living with both parents? ____________________If Not, which parent? _______________________

TB Status: ___________________________

Students are required to be screened for TB by PPD/Manitox skin test or Chest X-ray

TB Skin Test Date: _________________________ Result: _________________________________
OR
Chest X-ray: _________________________Date: ____________ Result: _________________________

The above requirement is waived if they have had a BCG vaccine in the last 5 years.

BCG Date: ____

Required Immunizations (parent or physician must provide dates). You may also just attach a copy of the records instead.

Diptheria	#1	#2	#3	#4	#5
Tetanus, Pertussis (often Given As DPT)					
Poliomyelitis					
Measles			often given together		
Mumps			As		
Rubella			MMR		

Recommended Immunizations: (Please fill in the date)

H-6 (Heamophilis Influenza): ____________________ Hepatitis A: ____________________________

Hepatitis B: ________________________________ Varicella (Chicken Pox): ___________________

Pre-rabies series: ______________________________ Typhoid: ______________________________

Japanese Encephalitis Series: ____

Please list any medications that your child takes routinely or for emergency and the purpose for which

they take them and frequency ____

____

Any medications to be administered by the Health Office must be sent in with written instructions. There is an "Authorizations for Medication Form" available in the Health Office and is included in this packet. Please send a copy of the doctor's prescription with it. It is very important that the nurse has your child's emergency backup medications (such as inhaler,epi-pen)

Reminder: Middle School & High school student's tetanus vaccinations should be repeated every 10 years and a 2nd measles or MMR should be done by grade 6.

SW

STUDENT'S HEALTH HISTORY

Does your child have any of the following? If yes, please supply details such as specific diagnosis and current treatment. For allergies, specify allergens and note severity of the allergies/common symptoms.

HEALTH PROBLEM	YES	NO	DETAILS
Allergies (Please review any past reactions to food, medicine, bee stings, environment)			
Asthma, (Please inform nurse of details especially if child requires the use of an inhaler)			
Neurological Xisorders			
Seizure disorder/epilepsy (inform nurse of type/frequency/medication and other details of seizure			
Diabetes (Please contact nurse with details)			
Frequent ear infections			
Hearing difficulties			
Frequent \eadaches			
Heart droblems			
Kidney/Urinary droblems			
Menstrual droblems			
Orthopedic(bone) problems			
Skin droblems			
Eye droblems			
Wears glasses/contact lenses			
Emotional problems			
Other health problems			

Blood Type: ________________Rh+ or Rh____

Explain any limits on physical activity (especially such as shortness of breath, loss of consciousness or irregular heartbeat) and list any illness or serious injuries that have occurred within the last 6 months.

MEDICATION PERMISSION (NON-PRESCRIPTION)

With your permission the school nurse can administer the following non-prescription medications without contacting you first.

For all ages

1. Acetaminophen for headache and minor discomfort (other names for this are Tylenol, Panadol,Paracetamol)
2. Strepsils throat lozenges for mild sore throat
3. Cough lozenges for cough
4. Topical ointments or solutions for minor wounds, skin irritations and insect bites/stings (list in available in Health Office)

For Middle and High School

1. Ibuprofin for menstrual cramps or sprains (anti-inflammatory)
2. Pepto-Bismol for nausea, mild diarrhea

(Please draw a line through any you do NOT want the nurse to give)

I give my permission for the school nurse to administer these medications listed above:

Yes No

Parent's Signature: ____

EMERGENCY PERMISSION:

I will hereby give permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

Parent's Signature: ______________________ Date: ____________________________

Reviewed Vy Nurse: ____________________ Date: ____________________________

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION TO STUDENTS

(DURING SCHOOL HOURS)

(Please attach prescription from the doctor with this form. Always send medicine in original packaging)

I request that during school hours my child:

Name of Student____

Grade________________________Birth date____

Be [iven:

Name of Medicine:____________________________________Dose:________________________

For the Treatment of:____

Times to be administered:____

Effective for what dates:____

Possible side effects:____

Any other special instruction:____

I realize the administration of this medication will necessarily be done by the school nurse:

Parent Signature:______________________________________Date_______________________

Under specific circumstances, i.e. age, or severe asthma/allergies the student may be approved to carry own medication.

Student has been approved to carry own medicine and medicate self? Yes No

Nurse's Gignature:____Date:________________

Principal's Gignature:____Date:________________

100 FEET ROAD, TARAMANI, CHENNAI 600 113 TEL: +91 44 2254 9000 FAX: +91 44 2254 9001 WEBSITE: WWW.AISCH.ORG

Note: If you answered yes to the questions regarding Allergies or Asthma, please fill out the accompanying documents

STUDENT ALLERGY INFORMATION

Name of Student:________________________________ Date of Birth:__________________

Grade:____

Allergic to:____

Note: If your child has different symptoms with different kinds of substances, please explain.

Also has asthma? Yes No

Check the symptoms your child has had with this allergy:

Hives, itchy rash
Swelling about the eyes, face or extremities
Itching and swelling of the lips, tongue or mouth
Itching and/or tightness in the throat, hoarseness, hacking cough
Nausea, abdominal cramps, vomiting and/or diarrhea
Shortness of breath, repetitive coughing and/or wheezing
Faint feeling, weak pulse, "passing out"
Other ____

Has the student ever had hospital emergency treatment for allergic symptoms? ____ No ____ Yes
Describe the reaction and treatment:

____

Student's allergy medications:

Medication	Dose/Amount	Time/s Given	Any other instructions

If student will be taking this medication at school, or may need any medication in case of reaction, please provide the Health Office with:

1. the medication in its original container or in a container labeled by the physician or pharmacist
2. a prescription or explanatory note from the physician for each medication
3. a medication permission form for each medication, completed by the parent

Additional information you wish the nurses to know:

____

Parent's Signature: ____ Date: ___________________

STUDENT ASTHMA PROFILE

Dear parent/s: On school records you indicated that this student has asthma. It is important to have at least annual health information for any student with a health condition. This information will be kept in the student's file in the AISC Health Office to provide guidance to the school nurses or other staff in the event of an asthma attack. If there is a change in the student's asthma management or any hospital visit for asthma, the parents are requested to notify the Health Office as soon as possible.

If the student will take or may need medication during the school day or on off-campus trips, please provide the Health Office with:

1. the medication in its original container or one labeled by the physician or pharmacist
2. a prescription or explanatory note from the physician for each medication
3. a medication permission form for each medication, completed by the parent

If the student will be carrying his/her inhaler, student should be instructed by parent and physician on proper use of the inhaler and when he/she should seek assistance from the school nurse. The student **must** seek assistance if no relief from inhaler or in significant problems with breathing or coughing.

Student Name: ____Grade/Class: _________________

Doctor who treats the student for asthma: ____________________________ Phone: ______________

Has the student been treated in the hospital for asthma in the past year and if so, what dates?

____

Is a peak flow meter used? No Yes How often? __________Best flow rate is ____________

How often does the student use the quick relief inhaler for relief of symptoms? (Albuterol, Salbutamol, or similar bronchodilator)

every day about once a week several times a month less than once a month

before exercise

Does the student use a nebulizer at home? No Yes How often? ___________________

Check the signs that your child shows during a typical asthma attack:

Coughing	Difficultywalking/talking
Wheezing	Bluish color of skin or nails
Feels frightened	Other _________________
Short of Breath	

Student's asthma triggers (substances/conditions which may cause asthma symptoms): check all that apply.

Exercise	Pollens	Molds
Respiratory infections	Strong odors or perfumes	Bee venom
Change in temperature	Chalk dust/dust	Smoke
Animals ______________	Carpets in the room	Other______
Foods ________________	Medicine___________________________________	

Student's medications: Please list all asthma medicines, doses, times given. Check (X) those that will be given at school.

Maintenance Medications: that which is taken daily to maintain control of asthma and prevent attacks. This medication is not for use for quick relief.

____

Quick-relief Medications: bronchodilator medicine which is taken immediately when symptoms occur. Indicate any special instructions, such as use of spacer.

____

Quick-relief will be kept at school:

with student   in health office

other_________________________________

Other comments: ____

Parents Signature: ____________________________________ Date: ___________________________