

**Parent Summary of Student Health History Form**

This form must be completed no longer than one year before your child’s entry into school**.**

**PART I - TO BE FILLED OUT BY THE PARENT OR GUARDIAN.**

**Please write your child’s name as it appears in their PASSPORT.**

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: | First Name: | Preferred Name: | Grade: |
| Date of Birth *(mm/dd/year)*: | Age: | Gender: Female Male | |

**STUDENT HEALTH HISTORY**

To the best of your knowledge has your child had any problem with the conditions listed below? Please Check. The physician should keep a copy of this form in the chart for their records. Explain all “**YES**” responses on the Comment column. Note additional Emergency Action Forms to be download for Allergy, Asthma, Diabetes, or Seizures.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Condition** | | **Yes** | **No** | **Comment** |
|  | | | | |
| **\*Allergies** (Food, Stinging insects, medications, etc.)  [(click to download](http://www.isb.bj.edu.cn/uploaded/ISB/Medical_Forms/Action_Plan_Allergy.pdf)) | |  |  |  |
|  | Serious Allergy Reactions |  |  |  |
| \***Asthma** or Breathing Problems ([click to download](http://www.isb.bj.edu.cn/uploaded/ISB/Medical_Forms/Action_Plan_Asthma.pdf)) | |  |  |  |
| Attention-Deficit / Hyperactivity Disorder (ADHD/ADD) | |  |  |  |
| Behavioral or Emotional Challenges Needing Special Support in School or at Home | |  |  |  |
| Other Diagnosed/ Identified Learning Challenges needing Special Supports (Please list challenges and specialized support needs) | |  |  |  |
| **Blood disorders** | Anemia |  |  |  |
| Sickle Cell Disease |  |  |  |
| Thalassemia |  |  |  |
| Other: Specify |  |  |  |
| Bone Fracture | |  |  |  |
| Born Premature | |  |  |  |
| \***Diabetes** ([click to download](http://www.isb.bj.edu.cn/uploaded/ISB/Medical_Forms/Action_Plan_Diabetes.pdf)) | |  |  |  |
| Hearing Impairment or Deafness | |  |  |  |
| Visual Impairment or Blindness | |  |  |  |
| Frequent Headaches | |  |  |  |
| Head Injury or Concussion | |  |  |  |
| Heart Problems | |  |  |  |
| Hospitalization (When, Where) | |  |  |  |
| Birth Defects | |  |  |  |
| Limits on Physical Activity | |  |  |  |
| Problem with Bladder | |  |  |  |
| Problem with Bowels | |  |  |  |
| **\*Seizures (**Epilepsy, Febrile convulsion)  ([click to download](http://www.isb.bj.edu.cn/uploaded/ISB/Medical_Forms/Action_Plan_Seizure.pdf)) | |  |  |  |
| Identified Need for Speech/Language Support or Therapy | |  |  |  |
| Special Diets | |  |  |  |
| **Surgery** | Appendectomy |  |  |  |
| Tonsillectomy |  |  |  |
| Hernia Repair |  |  |  |
|  | Other: Specify |  |  |  |
| **Other** : | |  |  |  |

**Mental and Physical Health /Other:** Is there anything else the school should know about your child’s physical, social or emotional well-being past or present?

Yes  No

If you would like to discuss this student’s health with school or school health personnel, check title:

Nurse  Teacher  Counselor  Principal

* **Should your child complain of minor pain or other problems while at school, the school nurse WILL administer over-the-counter medication such as:**
* Paracetamol (Tylenol/Panadol), Ibuprofen (non-aspirin)
* Antacid tablets (Tums), antispasmodic, Imodium (for stomach)
* Cough or Sore throat lozenges/syrup
* Antihistamines (Claritin, Benadryl)
* Moisturizing eye drops
* Topical ointment for rashes, etc.

I give permission to the school nurse to administer any of the medications listed above.

Yes  No

**PARENT CONSENT**

1. In the event that my child becomes ill and needs to go home, it is my responsibility to arrange transportation for my child to be picked up at school.
2. I understand that my child will undergo health screening by the school nurse.
3. If I or my emergency contacts are unable to provide consent, I agree to emergency medical treatment and / or transportation to a medical facility for any injury or illness deemed urgently necessary by designated ISB staff, with the understanding I will be notified as soon as possible.
4. I hereby verify the accuracy of the information above named student to engage in approved activities except those activities indicated by the licensed professional. I also give my permission for the certified athletic trainer or other qualified personnel to give first aid treatment to my son or daughter in case of injury.
5. I understand it is my responsibility to update the school nurse with the changes in my child’s condition or medical treatment.

|  |  |
| --- | --- |
| **Signature of parent/guardian:** | **Date:** |

**This information is being collected to provide for the student’s health and safety at school. This data will be treated as private and will be recorded in student health record. It will be shared only with school or emergency personnel on a “need to know” basis, unless you indicate otherwise.**