Student Health Record Form

Confidential Personal Health Questionnaire

Today's date: ____/____/________ (dd mm yyyy)

First Name: ______________________ Last Name: ______________________ Sex: ☐ M ☐ F

Grade: ________ Birth date: ____/____/________ (dd mm yyyy) Nationality: ______________________

Father's Name: ______________________ Mother's name: ______________________

Mother's Contact Numbers: Mobile: ______________________ Work: ______________________

Father's Contact Numbers: Mobile: ______________________ Work: ______________________

Child's mobile phone number: ______________________ Home number: ______________________

Emergency contact other than Parents (Name): ______________________

Emergency contact's mobile number: ______________________

Other siblings at AISB: ______________________

MEDICAL RELEASE AND PERMISSION TO TREAT

Should my child become acutely ill or injured while in attendance on the campus of AISB, or on an AISB school trip, the school team (doctor and nurse), first aid assistant, administrators and/or other members of the school staff have my permission to request medical assistance. I understand that the staff members of the school will take all necessary precautions at their disposal to ensure the safety of my child while attending AISB. I take responsibility to inform the school of any changes in my child's health.

Parent's/Guardian's Name: ______________________ Signature: ______________________ Date: ____________

PERMISSION FOR ROUTINE HEALTH SCREENINGS

I give my permission for the school team to perform a routine check of my child's vision, hearing, weight, height and a check for scoliosis (curvature of the spine) done on an yearly basis or as required.

Parent's/Guardian's Name: ______________________ Signature: ______________________ Date: ____________

MEDICAL HISTORY *(please check if your child has / had any of the following illnesses / conditions)*

- ☐ Chicken Pox
- ☐ Pertussis (whooping cough)
- ☐ ADD / ADHD
- ☐ Anemia
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Frequent tonsillitis
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Depression
- ☐ Serious injuries
- ☐ Bladder / Kidney infections
- ☐ Migraines
- ☐ Polio
- ☐ Other
- ☐ Cardiac Problems
- ☐ Speech problems
- ☐ Asthma
- ☐ Pneumonia
- ☐ Eye / Ear Problems
- ☐ Rheumatic fever
- ☐ Menstrual problems
- ☐ Bronchitis

Please explain any areas checked: ______________________

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Please give details of any operations your child has had: ______________________

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Is your child currently taking any prescription medication? ☐ Yes ☐ No

Name of medicine:	Frequency:	Dose:

If medication is to be administered during school hours, please contact the school medical office.
Phone: 021-204-4304 or 021-204-4317

ALLERGY

None known ______________________ Food ______________________

Medicine ______________________ Others ______________________

If your child has severe allergic reactions to an allergen and/or if they need to take special medication, please contact the AISB medical office at 021-2044304 / 021-2044317.

PERMISSION FOR MINOR MEDICATIONS

In case of necessity, the school medical team / the first aid assistant may give the following medicine as a single dose to my child:

- ☐ **Paracetamol, Ibuprofen, Tylenol** (for pain, high temperature)
- ☐ **No-spa, Debridat** (for intestinal cramps)
- ☐ **Sab Simplex, Triferment** (for intestinal discomfort)
- ☐ **Smecta, Ercefuryl** (for diarrhea)
- ☐ **Rennie** (antacids for stomach)
- ☐ **Motilium, Metoclopramid** (for nausea)
- ☐ **Visine, Claritine, Zyrtec** (antihistamines for allergies)
- ☐ **Ambroxol Syrup, Stodal Syrup** (cough)
- ☐ **Eferalgan, Coldrex Hot Rem, Fervex** (cold & flu)
- ☐ **Pomades, sprays, jells, creams** (antiseptics, pain relief, antihistamines, anti-inflammatory)

Parent's/Guardian's Name: ______________ Signature: ______________ Date: ________

PHYSICAL EDUCATION

- ☐ I allow my child to attend all physical activities at the school
- ☐ Performance in physical activities may be affected by the following: ______________________

IMMUNIZATION

RECORD	1ST	2ND	3RD	4TH	5TH	BOOSTER	BOOSTER
Diphteria/Pertussis/Tetanus DPT or DT							
Polio OPV or IPV							
Haemophilus Influenza type B (Hib)							
Hepatitis B							
Measles, Mumps, Rubella MMR							
Tuberculosis BCG							
TB skin test (PPD) Record result							
Hepatitis A							
Rotavirus Vaccine							
Varicella							
Influenza							
Pneumococcal vaccine PCV							
Meningococcal vaccine MCV							

REQUIRED MINIMUM IMMUNIZATIONS RECOMMENDED BY THE DEPARTMENT OF HEALTH IN ROMANIA:
DTP (Diphteria, Tetanus, Pertussis) – 2, 4, 6, 12, 36 months; DT (booster) 6, 14 years; BCG (Tuberculosis) birth, 14 years; Hepatitis B birth, 2, 6 months; MMR (measles, mumps, rubella) 1, 6 years; OPV / IPV (Polio vaccine) 2, 4, 6, 12, 36 months, 9 years. Your family physician will identify an appropriate schedule that will best safeguard the health of everyone and will advise you appropriately.

Doctor's Reference Form

To be completed in English by a physician

STUDENT'S NAME: ______________________ SEX: ☐ M ☐ F DATE OF BIRTH ___/___/_____ (dd mm yyyy)

REQUIRED INFORMATION:

Height: ________ Weight: _______ Blood pressure: ________ Hgb/Hct: ____________ Urine: ______________

Tuberculin skin test ____________ Date: ______________ Results: ______________________
Mantoux: ________________ Tine: ____

VISION (using vision chart):
w/o glasses R _________ L _________
With glasses R _________ L _________

HEARING:
R ____________ L ___________
Hearing (can repeat softly spoken words):

EXAMINATION	NORMAL	DESCRIPTION OF FINDING
☐ **Eyes**	☐	
☐ **Ears**	☐	
☐ **Nose, throat**	☐	
☐ **Oral cavity, teeth**	☐	
☐ **Respiratory tract**	☐	
☐ **Heart, circulatory system**	☐	
☐ **Genital – urinary**	☐	
☐ **Neurological**	☐	
☐ **Musculoskeletal**	☐	
☐ **Spine (curvature or other)**	☐	
☐ **Extremities**	☐	
☐ **Feet (flat, torsion etc.)**	☐	
☐ **Gait walking, running**	☐	
☐ **Abdomen**	☐	
☐ **Skin (rashes, eczema, etc.)**	☐	
☐ **Development for age**	☐	
☐ **Nutritional status**	☐	
☐ **Mental / behavioral status**	☐	
☐ **Speech**	☐	

CONCLUSION OF MEDICAL EXAM*:

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*If the student should be restricted from any physical activities, please note here: ______________________

I have examined the person herein described and have reviewed their health history as recorded on this form. It is my opinion that this person is physically able to engage in all school activities except as noted above.

Date: ______________________ Doctor's Signature & Stamp: ______________________

Print name: ______________________ Address: ______________________