



SAIGON SOUTH INTERNATIONAL SCHOOL

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STUDENT HEALTH FORM

THIS FORM MUST BE COMPLETED AND RETURNED TO SSIS PRIOR TO CLASS ATTENDANCE. ALL INFORMATION MUST BE IN ENGLISH.

NAME _____ GRADE _____
Last First Preferred name

BIRTHDATE _____ SEX _____
Day Month Year

EMERGENCY CONTACTS:

- Name _____ Relation to student _____
Last First
Phone (Home) _____ Phone (Work) _____ Mobile _____
- Name _____ Relation to student _____
Last First
Phone (Home) _____ Phone (Work) _____ Mobile _____
- Name _____ Relation to student _____
Last First
Phone (Home) _____ Phone (Work) _____ Mobile _____

EMERGENCY MEDICAL AUTHORIZATION:

- I authorize SSIS to refer my child to a hospital for urgent treatment in case the above emergency contacts cannot be reached. I shall bear financial responsibility for any such treatment.
- Permission for minor medications (Acetaminophen / Paracetamol):
 Yes No

Parent's Name in Print: _____

Parent's Signature: _____

Date: _____ / _____ / _____
Day Month Year

PHYSICIAN'S SECTION: (THIS SECTION MUST BE COMPLETED BY A PHYSICIAN.)

Student Name: _____

1. Disease history (give age)

_____	Rheumatic fever.	_____	Chicken pox.	_____	German measles.
_____	Measles	_____	Mumps	_____	Scarlet Fever
_____	Chronic ear infection	_____	Urinary tract infection.	_____	Glandular Fever
_____	Other				

2. Health problem/issues / Doctor diagnosed (give age).

_____	Visual problems	_____	Hearing loss	_____	Seizure disorder
_____	Heart disease	_____	Diabetes	_____	Orthopedic
_____	Asthma	_____	ADD/ADHD	_____	Other

3. Serious illnesses / operations / injuries / disabilities :) _____

4. Medications taken regularly (include prescription and over the counter medications)

<u>Medication</u>	<u>Dosage</u>	<u>Reason</u>	<u>Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Drug allergies (please specify) _____

6. Allergies (foods – insects – environment – please specify) _____

7. Immunizations:

Vaccine * indicates required immunization	Date of Immunization (Day / Month / Year)				
	1st	2 nd	3 rd	1 st Booster	2 nd Booster
* Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
* Diphtheria / Pertussis / Tetanus	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
* Diphtheria / Tetanus	___/___/___	___/___/___	___/___/___		
* Measles (Rubeola)	___/___/___	___/___/___	___/___/___		
* Mumps	___/___/___	___/___/___	___/___/___		
* Rubella (German measles)	___/___/___	___/___/___	___/___/___		
BCG	___/___/___				
Hepatitis B	___/___/___	___/___/___	___/___/___	___/___/___	
Japanese Encephalitis	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Varicella (Chicken pox)	___/___/___	___/___/___	___/___/___		
Other	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

