



Photo

Student Health Form

School Year	
Grade	

Student Information

Student's name: _____
 (as it appears in passport) First Name Middle Name Family Name

Student's Preferred (Nickname) Name: _____

Gender: (M/F) _____ Date of Birth: _____
 Day Month Year

Blood Group _____ Rh Factor _____ Nationality _____
 (Negative/Positive)

Father's Name: _____ Cell Phone: _____

Mother's Name: _____ Cell Phone: _____

Home Address in Thailand: _____

Telephone: _____

Emergencies: Please name another person (other than parents and guardian) who we can contact locally.

1. Contact person: _____ Home: _____ Cell Phone: _____

2. Contact person: _____ Home: _____ Cell Phone: _____

Health History

The following information is strictly confidential and will be shared only by the school staff as required to ensure the well-being of your child and the school population.

Please indicate (yes/no) if your child has a problem with any of the following:

Asthma, wheezing, chronic cough or other breathing difficulties	Epilepsy, seizures, convulsions, or unexplained losses of consciousness
Orthopedic or back problems; or any condition which impairs full movement	Allergies (e.g. to pollen, dust, insect bites, foods, chemicals, drugs etc.)
Diarrhea or stomach problems	Life threatening allergic reactions
Frequent headaches, migraines	Sleeping difficulties
Congenital heart, cardio vascular problem	Emotional problems
Visual problems (squints, glasses, color blindness, itchy or red eyes)	Ear problems (e.g. deafness, tinnitus, infections, aches or 'swimmers ear')
Abnormal bleeding (haemophilia, thalassemia)	Communicable diseases
Dietary restrictions (religious/medical)	Tropical diseases
Physical disability (e.g. speech, sight, hearing or movement)	Menstrual Issues
Urinary infections	Diabetes
Thyroid problems	Other

***Please give additional information if you have indicated "yes" to any of the above:** _____

Does your child have any allergies (to medication, food, etc...) that you are aware of?

Yes No Please specify known allergies: _____

Does your child have any illness or condition that the school should be aware of?

Yes No If so, please state: _____

Does your child receive any medication or medical treatment, either regular or occasionally?

Yes No If so, please indicate: _____

Has your child even been hospitalized for any reason?

Yes No If so, for what reason? _____

Does your child have any limitation for Physical Education?

Yes No If so, please explain: _____

Immunization History

Immunization record must be submitted within two months after initial enrollment date.

Please fill in the dates that immunizations were given.

Vaccine	1 st dose (dd/mm/yy)	2 nd dose (dd/mm/yy)	3 rd dose (dd/mm/yy)	1 st booster (dd/mm/yy)	2 nd booster (dd/mm/yy)	Remarks
Hepatitis B						
DPT/DT (Diphtheria/Pertussis/Tetanus)						
Polio						
MMR (Measles/Mumps/Rubella)						
JE (Japanese Encephalitis)						
HIB (Haemophilus Influenza type B)						
Hepatitis A						
Chicken pox						
Influenza						
Typhoid						
Other						

Emergency Treatment Authorization: In the event of an emergency when immediate observation or treatment is deemed necessary by the school nurse/administration, I authorize the school to send my child to the medical facility most readily accessible.

Permission to administer Panadol/Tylenol (Acetaminophen)

Yes No

Parent's Signature _____ Date _____

It is the responsibility of the parents/guardian to notify the school nurse in writing of any changes to the information given in this form e.g. changes of address, telephone number, physical condition or medications.