Photo

ISE
INTERNATIONAL SCHOOL EASTERN SEABOARD
25 years of personalized learning

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	1st dose (dd/mm/yy)	2nd dose (dd/mm/yy)	3rd dose (dd/mm/yy)	1st booster (dd/mm/yy)	2nd 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.