HEALTH RECORD Marymount International School

This form must be completed accurately by both a parent/guardian and a physician before the child may attend school. A new Health Record form must be completed when moving between Early Childhood, Elementary School, Middle School, and High School. Some medical conditions might require more specific and frequent health assessment depending on the child's individual condition.

Please use BLOCK capitals

Name of student ________________________________ Grade entering ______________
Family First Middle

Date of Birth ______________ **Sex:** M ___ F ___ **Nationality** ______________________
Day/month/year

MEDICAL HISTORY:

Does your child have or ever had any of the following:

Seizure Disorder: Infantile convulsions ________ febrile convulsions ________ epilepsy ________

Asthma ______________ Diabetes: ______________ Migraine: ______________

If YES, please explain: ____

____

Any Allergies to medication, insect bites, food, environment? Yes ______ No ______

If YES, please indicate type of allergy and treatment needed: ______________________

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Any dietary requirements? Yes ______ No ______ If YES, please state requirements: __________

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Please explain any significant medical conditions of which the school should be aware: __________

____

Does your child:

Wear glasses or contacts? ____________________ Have hearing problems? ______________

Take medication on a regular basis? ______________________________________

Has your child ever been hospitalized or undergone surgery?

____

Is your child currently undergoing professional counseling/therapy? If YES, please explain: __________

____

In case of a medical emergency I understand that all efforts will be made to contact the parents/guardian. If unsuccessful, I authorize the school to give or obtain the necessary medical attention:

In case of emergency and the parent/guardian is not available please contact: Name: ______________

Home Telephone: ______________________ Mobile Telephone: ______________________

Parent/Guardian Signature: ______________________________ **Date:** ______________

5/10

IMMUNIZATIONS Please fill in the chart below:

You may submit a copy of your child's immunization booklet, or complete the dates administered below:

At age	Immunization	Date
3 months of age	1st anti Hepatitis B	
	1st dose DTPa Diphtheria / Tetanus / Pertussis	
	1st dose Polio	
5 months of age	2nd anti Hepatitis B	
	DTPa Diphtheria / Tetanus / Pertussis	
	Polio	
11-12 months of age	3rd anti Hepatitis B	
	DTPa Diphtheria / Tetanus /Pertussis	
	Polio	
12-15 months of age	MMR Measles, Mumps and Rubella	
3 years	4th polio	
4-6 years	DTPa and Measles, Mumps booster	
11-15 years	DT booster and every 10 years thereafter	
	Chicken Pox vaccine	

Insurance Policy Number: ____________________

Medical Italian ASL Number: ____________________

PHYSICAL EXAMINATION: to be completed and signed by a *licensed physician*

Height: __________ Weight: __________ Heart: __________ Heart Rate: __________

Nose: __________ Mouth: __________ Teeth: __________ Lungs: __________

Skin: ____________________ Abdomen: ____________________

Scoliosis: ____________________ Reflexes: ____________________

Hearing: ____________________ Vision: ____________________

Development: ____________________ Menstrual History: ____________________

General Appraisal/Comments: ____________________

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I hereby certify that this student is physically fit to partake in sports activities connected with Marymount International School.

Doctor's Name: ____________________ **Tel:** ____________________

Doctor's Signature/Stamp: ____________________

Date: ____________________