



Student Health Form

New & Returning Students

To be completed by parents: _____ Reviewed by: _____ Date: _____

Student's Family Name: _____
First Name: _____ Middle Name: _____ Male: ____ Female: ____
Grade in August: _____ Date of Birth: _____
Father's Name: _____ Father's Languages: _____
Mother's Name: _____ Mother's Languages: _____
Home Address in China: _____
Home Phone: _____
Mother's Cell: _____
Father's Cell: _____ Business Phone: _____
Emergency Contact in Wuhan if parents cannot be reached :
Name: _____ Relationship to student: _____
Phone: _____

Does your child have International SOS or other emergency medical evacuation coverage?

Name of company: _____
Contact #: _____
Policy #: _____

If you want your child to take medication at school, you must send a note with the medication and give the name of the medication, dose (how much), time to take the medication, and for how many days.

The nurse's office has the following medications. Please check the box next to the medication which gives the school nurse permission to give it to your child if needed.

- Throat Lozenges-sore throat relief
- Acetaminophen/Paracetamol (Tylenol) for headaches, fever and cramps
- Ibuprophen (Motrin) for headaches, fever and cramps
- Diphenhydramine (Benadryl) for allergic reactions
- Topical ointments and lotions for grazes, cuts and rashes

THE BELOW IMMUNIZATION MUST BE CURRENT BEFORE A STUDENT IS ADMITTED TO WYIS ACCORDING TO SCHOOL POLICY. Please write the DATES for BOTH the scheduled and booster immunizations.

*Some countries may have slightly different schedules for these vaccinations. Some vaccinations may be combined and given in 1 vaccine (ex. DPT, MMR).

Type	Date (mm/dd/yy)				
	1st	2nd	3rd	4th	5th
Polio (Oral) (OPV): 2, 4, 6 & 12-18 months, 4-6 years old OR					
Polio (Inactivated) (IPV): 2,4,6-18 months, 4-6 years old					
Diphtheria, 2, 4, 6 & 18 months, 4-6 years old, (booster every 5-10 years)					
Pertussis 2, 4, 6 & 18 months, 4-6 years old, (booster every 5-10 years)					
Tetanus 2, 4, 6 & 18 months, 4-6 years old, (booster every 5-10 years)					
Measles: 12-15 months; 4-6 years					
Mumps: 12-15 months; 4-6 years					
Rubella: 12-15 months; 4-6 years					
Hepatitis B (3-5 shots)					
Tuberculosis	Vaccine (B.C.G.)				
	Chest X-ray				
	OR - Skin test (PPD/Mantoux)-within one year prior to admission	Result + -			

THE FOLLOWING VACCINES ARE <u>NOT</u> REQUIRED BUT ARE RECOMMENDED					
Chickenpox 12-18 months					
Hepatitis A					
HiB (Haemophilus influenza type B)					
Pneumococcal conjugate					
Japanese Encephalitis					

***PLEASE ALSO ATTACH A PHOTOCOPY OF YOUR CHILD'S VACCINATION RECORD (If available)**

Allergies? (Medication, Food, Pollen, Grass, Trees, Dust, Mold, Other?)

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Medications taken daily or on a regular basis (Vitamin supplements, natural/home remedies,

Chinese traditional medicines) Substance: _____ Regularity: _____

Substance: _____ Regularity: _____ Other: _____

Dental

Has your child had a dental check-up in the past two years? Yes No

Date of check-up? _____

Health Conditions

Does your child have a history of any of the following conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Glasses or Contacts | <input type="checkbox"/> Chronic Diseases |
| <input type="checkbox"/> Asthma* | (circle which one/s) | <input type="checkbox"/> Frequent Stomach aches |
| <input type="checkbox"/> Breathing Problems* | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Seasonal Respiratory Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bladder or Kidney Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> ADHD /ADD | <input type="checkbox"/> Blood or clotting disorders* |
| <input type="checkbox"/> Seizures (Epilepsy)* | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Severe Menstrual Cramps | <input type="checkbox"/> Frequent Nose Bleeds |
| <input type="checkbox"/> Serious injuries | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Hearing Problems | |
| <input type="checkbox"/> Bone or Joint Problems | <input type="checkbox"/> Teeth or Mouth Issues | |
| <input type="checkbox"/> Serious Accidents | <input type="checkbox"/> Anxiety/ Depression/ Bipolar (circle which one/s) | |

Any items with an (*) require a follow-up assessment tool to be filled out through the School Nurse's office.

Please explain any checked boxes and give any additional information that would help the teachers or school nurse in the care of your child during the school day:

PARENT'S SIGNATURE: _____

Date: _____