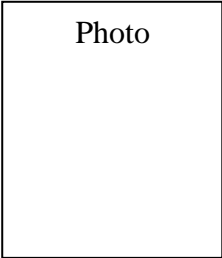




HARROW
INTERNATIONAL SCHOOL
BANGKOK



Student Health Record

| | | |
|--|---------------------|-----------------------------|
| Child's Surname | Forename | Nickname |
| Year/ Tutor Group: | Date of Birth: | Male / Female |
| Child's Home address | | Tel: (Home) |
| Name: | Home Address | Tel: (Work / Mobile) |
| Mother: | | |
| Father: | | |
| Guardian: | | |
| Blood Group: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O RH Titer <input type="checkbox"/> Positive <input type="checkbox"/> Negative | | |

Health Condition: Please indicate any of the following conditions that your child has previously or is currently receiving medical attention for:

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Congenital Anomalies |
| <input type="checkbox"/> Convulsion/ Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Kidney/Urinary tract problem | <input type="checkbox"/> Orthopedic problems | <input type="checkbox"/> Persistent nosebleeds |
| <input type="checkbox"/> Period pain | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Rashes/ skin Problems |
| <input type="checkbox"/> Frequent stomach aches | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Others |

Please explain any indicated condition(s) specifying information that would help the school to take good care of your child during the school day. It is very important to inform the school nurse / class teacher regarding any serious conditions for immediate treatment/actions.

| | | |
|--------------|--------------|------------------------------|
| Allergies: | Reaction: | Routine Medication and Dose: |
| | | |

Has your child ever had surgery or major injury? Please specify

Is your child able to fully participate in P.E. / Sport/ Swimming Yes No Please explain

Note: It is important that parents provide the accurate and updated health condition throughout the year for the school nurse to give the appropriate care to your child.

Emergency Medical Treatment Consent Form

I give permission, in the event of an emergency or sudden illness, for the School Nurse to give medical treatment to (Child's name) _____

I understand that I will be immediately contacted.

Note: In the event of a Medical Emergency, this Form will accompany your child to the hospital so that medical treatment can be given.

Signature:

Relationship to child:

Name in Full:

Date:

The Administering of Tylenol

The administering of all medications requires Parental written permission and this must be kept in the Health Center and be administered by the School Nurse.

With your permission, the school nurse may give your child Tylenol or its equivalent for minor aches and pains such as head ache, tooth ache, dental pain, stomachache, menstrual cramp, or fever. Please indicate, sign and date the section below.

- . Nurse has my consent to give (Child's Name) _____ my son/daughter, Tylenol or its equivalent during the school time.
- . Please do not give my son/daughter Tylenol or its equivalent at school.

Signature:

Relationship to child:

Name in Full:

Date: