EASTWOOD INTERNATIONAL SCHOOL

"Children, Our Purpose And Our Future"

MEDICAL FORM

PLEASE PASTE RECENT PASSPORT SIZE PHOTO OF APPLICANT HERE

(For Official Use) Student # ____________ Grade ________ Academic Year ____________

PARENTAL APPROVAL TO ADMINISTER HEALTH CARE AT SCHOOL

Name of applicant (BLOCK LETTERS)

____________	____________	____________	____________
First	Middle (If applicable)	Father's name (If applicable)	Family or last name

Date of birth ____________ Gender: ☐ Female ☐ Male
MM/DD/YY

Home Number ____________ Mother's Phone # ____________

Father's Phone # ____________

Persons to inform in case of emergency if parents or guardians are unreachable:

1. Name ____________ Relation ____________ Home Phone ____________ Cell Phone ____________
2. Name ____________ Relation ____________ Home Phone ____________ Cell Phone ____________

Pediatrician's Name ____________ Phone #(s) ____________

The school will not administer any medication nor provide any health care or screening to children without written permission from their parents. We urge you to complete this form and return it with the application. Should you need any clarification, please do not hesitate to call our nurse: Mrs. Celine Kettaneh.

☐ Yes, the school nurse has my permission to give my child over-the-counter medications(e.g. analgesia, antipyretic, cough medicines, and throat lozenges) or antiseptic agents for wounds (in case needed).

☐ Yes, if any child or legal ward of mine enrolled at Eastwood International School appears to require immediate medical treatment and/or surgery where neither my spouse nor I are available to authorize a doctor to proceed therewith, I authorize the School's Director or, in his/her absence or inability to act, the Acting Director to take whatever action is deemed necessary to ensure the provision of any necessary permit or authorization.

☐ Yes, I hereby authorize the school nurse to release information contained in this document to other health professionals or school administrators whenever it is medically needed for the care of my child.

The school urges you to complete this form as accurately as possible. Information requested herein in addition to the school screening examination are done in order to ensure that our students are at their maximal learning capacity and able to participate in the various school activities. They are not a replacement for your child's physician's medical assessment.

☐ Yes, the school nurse has my permission to perform a physical screening if necessary (height, weight measurements, dental, hearing & vision check) for my child on an annual basis.

BLOOD TYPE OF CHILD: ____________

My signature acknowledges that I have read and understood all the above:

Parent's/Guardian's signature

____________	____________	____________
Parent's / Guardian's Name	Signature	Date

STUDENT'S MEDICAL HISTORY - to be completed by parent / guardian

1. History:

Check any of the following the student has or may have had:
Please note: none of the information on this form will be used in admissions decisions.

- ☐ Abnormal bleeding/bruising
- ☐ ADHD/ADD
- ☐ Allergies (medications, bee sting, pollen, food, etc.)
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Anorexia / Bulimia
- ☐ Broken bones/stress fracture
- ☐ Cancer
- ☐ Chest pain during exercise
- ☐ Cogenital heart disease
- ☐ Concussion or head injury
- ☐ Constipation
- ☐ Diabetes
- ☐ Dislocation (shoulder, etc.)
- ☐ Ear problems
- ☐ Eczema
- ☐ Eye or vision problems
- ☐ Fainting with or without exercise
- ☐ Gastrophageal reflux disease (GERD)
- ☐ Hearing impairment
- ☐ Heart murmur/palpitations
- ☐ Heat stroke or heat exhaustion
- ☐ Hepatitis/jaundice
- ☐ High blood pressure
- ☐ Hospitalization
- ☐ Learning difficulty
- ☐ Loss of consciousness
- ☐ Loss of eye sight
- ☐ Migraine
- ☐ Obesity
- ☐ Positive PPD (Tuberculosis skin test)
- ☐ Rheumatic fever
- ☐ Scoliosis (curvature of spine)
- ☐ Seizures
- ☐ Sickle-cell disease
- ☐ Single organs (kidney, eye, etc.)
- ☐ Speech problems
- ☐ Sudden death in the family before age 35
- ☐ Sudden death in the family before age 50
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Undescended testicle
- ☐ Wheezing or cough during or after exercise

If any of the above is checked, please explain or attach a medical report:

____

____

Date of diagnosis: ____________________ Treatment: ______________________________

____

2. Has your child undergone any major surgeries? ____________ ____________ ____________

Type Body Site Date

3. Immunizations: Attach a copy of recent vaccination records.

4. Does the student have any other medical condition about which should be informed? ☐ Yes ☐ No *if yes, please explain*

____

____

____

5. Is your child taking any chronic medication(s): ☐ Yes ☐ No *if yes, please list:*

	Medication name:	Dose:	Frequency/Times of day:
a.			
b.			
c.			

6. Please state any medication / or food your child is allergic to:

____

____

7. Does your child have a prosthesis (medical device)? ☐ Yes ☐ No *if yes, please specify:*

____

____

Parent's/Guardian's signature verifying above information

____________________ ____________________ ____________________

Parent's / Guardian's Name Signature Date

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