ST. JOHN'S INTERNATIONAL SCHOOL
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PLEASE ATTACH
PHOTO HERE

Health Record

Surname of student : _____ Sex : _____ Grade : _____
First / middle name : _____ Date of birth : ____ / ____ / ____ (day) (month) (year)
Address in Belgium : _____
_____ Tel. n° : _____
Mobile n° father : _____ Office n° : _____
Mobile n° mother : _____ Office n° : _____
Family doctor (Belgium) : _____
_____ Tel. n° : _____
Family dentist (Belgium) : _____
_____ Tel. n° : _____

IN CASE OF SICKNESS OR ACCIDENT, PLEASE NOTIFY :

Name : _____ Address : _____
Tel. n° : _____ Mobile : _____ Office : _____
Name : _____ Address : _____
Tel. n° : _____ Mobile : _____ Office : _____

IMMUNIZATION HISTORY	FILL IN DATES IMMUNIZATION GIVEN							REMARKS
Diphtheria / Pertussis / Tetanus								
Polio								
Diphtheria / Tetanus								
Tetanus								
Measles								
Mumps								
Rubella								
M.M.R.								
Whooping Cough								
Hepatitis A								
Hepatitis B								
Hepatitis A/B								
Typhoid								
Varicella / Chickenpox								
H.I.B.								
Rabies								
Meningitis C								
Yellow Fever								
B.C.G.								
Variola / Small-pox								

Last TB / PDD Test : _____ Result : _____
Last physical check-up : _____ Last hearing test : _____ Result : _____
Last dental check-up : _____ Last vision test : _____ Color-blind : _____
Does your child wear glasses / contact lenses ? Yes / No Specify : _____
Serious injuries : _____
Does your child have sport limitations ? Yes / No Specify : _____
Surgery : _____ Hospitalization : _____
Specify : _____ P.T.O.

Has your child had, or been recommended to have :

a) Remedial education : _____

b) Speech therapy : _____

c) Psychological counselling : _____

Specify : _____

Any other information you feel should be made known to the school in the interest of the child :

Specify : _____

HEALTH / CHILDHOOD HISTORY

	YES	NO	REMARKS
Dizziness / fainting / headaches			
Convulsions / fits / epilepsy			
Concussion			
Dental caps / bridges / braces / plates			
Asthma / eczema / hayfever			
Diabetes			
Heart problems / murmur			
Bone / joint injury			
Chronic illness or condition			
Ear tubes			
Chickenpox			
Measles			
German Measles / rubella			
Whooping Cough			
Mumps			
Scarlet Fever			
Rheumatic Fever			
Pneumonia			
Tonsillectomy			
Adenoidectomy			
Tuberculosis			Medicated with :
Allergies			
Drug allergies			

CURRENT MEDICATIONS	REASON	DOSAGE

I give permission to administer, if necessary, **PARACETAMOL** / **IBUPROFEN** **YES** / **NO**

I accept that my child will undergo routine School physical check-ups, and a yearly TB skin test.

IF YES, PLEASE SIGN HERE, _____ (Parent / Guardian)

All prescription medications need a written note from the parents / guardian. All medications, along with the note must be submitted to the school nurse. Medications need to be in the original pharmacy containers, and marked with the student's name, dosage, schedule and instructions. Students are not allowed to carry any prescription / controlled medications (such as Ritalin, pain pills, antibiotics, etc.)

I approve that my child be given Emergency Medical Treatment if required.
I understand that by Belgian law, my child will undergo routine school physical check-ups, and tuberculin test.

Date : _____ Signature : _____ (Parent / Guardian)