Singapore International School Pracha Uthit
Student Health Information

Student's family name:________________________________ **First name:**___________________________________

Gender: ☐ **Male** ☐ **Female** **Date of Birth:**_______________ **Nationality:**___________________________

Place of Birth:_______________________________ **Religion:**_____________ **Blood Group:**________________

Father's Name:_______________________________ **Phone:**_____________ **Mobile:**_____________ ☐ **Divorced**

Mother's Name:______________________________ **Phone:**_____________ **Mobile:**_____________ ☐ **Divorced**

Home Address: ____

With whom does the student live? ☐ **Father** ☐ **Mother** ☐ **Both** ☐ **Guardians**

Guardian's name: ____________________________________ **Phone:**_____________ **Mobile:**_______________

Emergency contact name: ________________________________ **Phone :**_____________ **Mobile:**_______________

Hospital name : ____ **Phone :** _________________

Doctor's name: ____**Phone :** _________________

Please inform us about your child's known health conditions:

☐ **My child has no known allergies. Signature:** ____________________________ **Date:** ______________

☐ **Allergies:**

My child is allergic to (food, drug, insects, other)	*Describe Reaction*	*Describe Treatment*

☐ **Immunizations:**

Type	*Number/Date*	*Type*	*Number/Date*	*Type*	*Number/Date*
BCG		**Hepatitis B**		**Mumps**	
Chicken Pox		**Hib**		**Rubella**	
DTP		**Japanese B Encephalitis**		**OPV**	
Hepatitis A		**Measles**		**Typhoid**	

Record of Illness

Illness	No	Yes
Chicken Pox	☐ No	☐ Yes
German Measles	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes
Measles	☐ No	☐ Yes
Mumps	☐ No	☐ Yes
Poliomyelitis	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes
Typhoid	☐ No	☐ Yes
Whooping Cough	☐ No	☐ Yes

Other ____________________________

Health Problems **Details**

1. Asthma (หอบหืด) ____________________________________
2. ADD/ADHD ____
3. Behavior problem ____________________________________
4. Congenital abnormities ______________________________
5. Convulsion/Epilepsy (โรคลมชัก)________________________
6. Diabetes (เบาหวาน) __________________________________
7. Frequent headache___________________________________
8. G6PD ____
9. Hearing difficulty____________________________________
10. Heart Condition_____________________________________
11. Menstrual Problem___________________________________
12. Orthopedic Problem (โรคกระดูก) ______________________
13. Scoliosis (กระดูกหลังคด) _______________________________
14. Speech Difficulty ____________________________________
15. Visual Problems ____________________________________
16. Other ____

☐ Is there any reason for the child to be restricted from physical educational activity?

If yes, please specify ____

☐ Is the child under medical care or routinely taking medication prescribed by a doctor?

If yes, please specify ____

I give permission for emergency measures to be initiated in case of accident of illness with the understanding that I will be notified.
I certify that all information given on this record is complete and correct.

Parent's signature ____ Date __________________

Doctor's signature ____ Date __________________

Further information
1. Please inform the school if your child has been given any medication prior to coming to school.
2. If your child needs to take medicine during school hours, please bring it to the health room for the nurse to administer. Please write your child's name, class and the time and dosage of the medication to be taken.
3. No medication will be administered without the permission of the parent. Student may not keep any type of medication with them.