

Health Information/Release Form

Student's name: _____ Birth Date: _____

Grade: _____

Note: Parent/Guardian Consent and Agreement for Emergencies.

As parent/guardian, I give consent to have my child receive first aid by appropriate staff, and if necessary, be transported to receive emergency care at the medical facility of my choice as stated below. I understand that I will be responsible for all charges not covered by my insurance. I give consent for the emergency contact person listed to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least once a year.

Date

Parent/Guardian Signature

Relationship to student

Student's Health Insurance Information

Name of Insurance Plan _____ ID# _____
Subscriber's name (on insurance card) _____

Transport Arrangement in an Emergency Situation

Ambulance Service _____

Student will be taken to: _____

(Parents/guardians are responsible for all emergency transportation charges)

Medical History

Allergies: _____ Diarrhea: _____ Rheumatic fever: _____
Emotional disorders: _____ Skin disorders: _____ Anemia: _____
Eye disorders: _____ Tuberculosis: _____ Bleeding disorders: _____
Measles: _____ Mumps: _____ Chicken pox: _____
Pneumonia: _____ Asthma: _____

Other: _____

Remarks: _____

Has the student ever been hospitalized or had any broken bones? If yes, please explain: _____

Is the student presently taking any medication? If yes, please explain: _____

RELEASE: I hereby release Hokkaido International School and the employees/staff from any claim or liability whatsoever for the administration of medications to my child in accordance with the instructions which I have provided herein, and for the administration of first aid and the transportation of my child in the event of an emergency.

Signature

Relationship to student

Signature

Relationship to student

Immunization Records

	DPT	Polio	MMR	Hep A	Hep B	HIB	TD	T.B. Test
Birth								
2 month								
4 month								
6 month								
6-18 months								
12-15 months								
15-18 months								
4-6 years								
11-12 years								
14-16 years								

Daily Medication Indication

Dosage: _____

* Recommended schedule

Hepatitis B series of 3 immunizations: should be given to the previously immunized at either 11-12 years or 13-14 years.

Haemophiles (HIB or HBIC) influenza type B Vaccine. Usually the series is given in combinations with DPT.

Disabilities and Actions

Please check the appropriate restrictive conditions, and list emergency actions that should be taken:

Asthma Bronchitis Diabetes Over activity Heart problems Epilepsy-seizures

Sore throat Nose bleed Ear infections Abdominal pains Dizziness Skin Disorders

Eye disorders Kidney disorders Other _____

Student Health Card

Student Name: _____

Sex: _____ Birth Date _____ Grade: _____

Legal Guardian #1 Name: _____

Telephone numbers Home: _____ Work: _____

Legal Guardian #2 Name: _____

Telephone numbers Home: _____ Work: _____

Doctor's Name: _____

Telephone Number(s): _____

Dentist's Name: _____

Telephone Number(s): _____

Blood Type: _____

Emergency Contact: _____

Telephone Number(s): _____

Are there chronic health conditions/diseases of disabilities, (physical or emotional) that may restrict student activity? If yes fill out the disabilities and actions sections.

Does the student require daily medication? _____ If yes, fill out the daily medication section above.

Do you authorize HIS to administer medications including, but not limited to the following, to your child if necessary: Anti-Inflammatory/ Anti-fever medicine, Antacid, Stomach medicine, Cold Medicine, Anti-histamine, Eye Drops, Anti-itch ointment, Antibiotic ointment

All: _____ None: _____

Any restrictions you would like to impose:

List all Allergies:

Drugs: _____

Food: _____

Animal/Insect: _____

Environment: _____

Other: _____

STANDARD PHYSICAL EXAMINATION

Student's Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Sex: _____ Nationality: _____ Grade: _____
m/d/y

Height _____	Blood pressure _____	Pulse rate _____
Weight _____	Temperature _____	Respiration _____
Nervous system _____	Bone/Joint Problems _____	Lungs asthma _____
Muscle tone _____	Ears/hearing test _____	Abdomen _____
Seizures _____	Nose _____	Extremities _____
Blood Disorders _____	Mouth/speech problems _____	Spine _____
Skin _____	Throat _____	Eyes/vision _____
Thyroid _____	Lymph glands _____	Heart problems _____
Diabetes _____		
Vision: R _____ L _____	Glasses: R _____ L _____	

Laboratory results:

Urine _____ CBC: _____ Stool: _____

Chest x-ray (if needed): _____

History of surgery: _____

All vaccinations completed: Yes [] No []

Any history of dizziness, faintness or difficulty breathing during exercise: _____

On the basis of the examination on this day, I approve this child's participation in:

Physical Education Yes [] No [] Athletic Sports Yes [] No []

If no please explain why. Modified: _____

Physician's name (please print): _____

Physician's signature: _____

Address: _____

Telephone: _____ Date of examination: _____

License number _____