

Health Form

Please type or print neatly.

Student's Name _____
Last First Middle

Preferred name _____ Gender _____
Male / Female

Phone _____

Home Address _____

Date of Birth _____
Month Day Year

Nationality _____

Father's Name _____

Religion _____

Mother's Name _____

Resides with _____
Optional

Alternate person(s) to contact in case of emergency:

Names(s)	Relationship to Student	Tel. Number / s
_____	_____	_____
_____	_____	_____

HEALTH HISTORY

Does your child have any allergies (to medication, food or others) that you are aware of?

Yes ☐ No ☐ Please specify known allergies _____

Does your child have any illness or disability that the school may need to be aware of?

Yes ☐ No ☐ If so, please state _____

Does your child receive any medication or other medical treatment either regularly or occasionally?

Yes ☐ No ☐ If so, please indicate _____

Has your child ever been hospitalized for any reason?

Yes ☐ No ☐ If so, for what reason? _____

If you know your child's blood type, please indicate?

_____ Rh group _____
(A, B, AB, O) + or -

AFFIX
YOUR
2 x 2
PHOTOGRAPH
HERE

ADDITIONAL INFORMATION

Do you have a family doctor?

Yes ☐

No ☐

Doctor's Name _____ Phone _____

Hospital Name & Address _____

AUTHORIZATION

I give consent for my child to receive the following:

	YES	NO
1. Minor first aid by nurse at the school clinic (medication & treatment)	☐	☐
2. Emergency care at the school clinic	☐	☐
3. Transportation to a hospital of the school's choosing, in severe or emergency cases	☐	☐

NOTE: If you checked "**NO**" to numbers 1, 2, and 3, the clinic will not provide any health care for the student, until alternate emergency care instructions (from parents or official guardian) are on file with the Clinic.

Please note: Brent International School NURSES will provide care for any minor medical problem/s which may occur during the school day.

- ☐ In the event that my child requires emergency medical care and I cannot be reached, I give permission to Brent School authorities to act on my behalf. I also authorize them to sign any necessary release forms required by the hospital.

Name of Parent / Official guardian (Please Print)

Signature

Date

OTHER REQUIREMENTS

- ☐ Please attach a photocopy of your child's immunization record.

Date Submitted _____.

- ☐ If your doctor makes any recommendations or restrictions during the school year regarding your child's health, please submit the recommendation or certificate to the school as soon as possible. Otherwise, your child will be considered "PHYSICALLY FIT" and able to participate in Physical Education (P.E.) activities required by the curriculum and in other activities that may be part of the school program.