

# STUDENT HEALTH RECORDS



## THE AMERICAN SCHOOL OF KINSHASA

*Excellence in Education 1961*

Student's Name: \_\_\_\_\_ Grade \_\_\_\_\_  
Last (Family Name) First Name Middle Name

Date of Birth: \_\_\_\_\_ (MM/DD/YYYY)

Father's name \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Mother's name \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Guardian's name (if not parents) \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Kinshasa Street Address \_\_\_\_\_

Should your child need to go home during the day and we are not able to contact you, is there someone at your house who would care for your child?

Yes  No  If yes, please provide the name of the person: \_\_\_\_\_

Is your child capable of directing someone to your home? Yes  No

If your child is not able to find your house, is there someone at TASOK who knows where you live? Name: \_\_\_\_\_

### **Authorization**

TASOK has my permission to give 1 or 2 Tylenol /Panadol 500mg tablets for minor pain while my child is at school. Yes  No

In the event of minor illness, injury or emergency, I authorize TASOK personnel to treat my child. Yes  No

I authorize the clinic or doctor below to treat my child. (In an emergency TASOK will seek available medical care if deemed necessary.)

Name of clinic \_\_\_\_\_ Telephone # \_\_\_\_\_

Name of Doctor \_\_\_\_\_ Telephone # \_\_\_\_\_

### **HEALTH ASSESSMENT** Does your child have any of the following concerns? (Please check yes or no)

Allergies (Drugs, Food, Insects)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Meningitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nosebleeds	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ear Problem/Deafness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sickle Cell Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech Impairment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excessive Bleeding/Bruising	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye/Vision Impairment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Wears Glasses	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Wears Contacts	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Disease/Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Wears Hearing Aid	Yes <input type="checkbox"/> No <input type="checkbox"/>

If the answer to any of the following questions is yes, please provide details: \_\_\_\_\_

### **PRESENT HEALTH** (please check yes or no)

1. Is your child currently in good health? Yes  No

2. Do you think your child is fit to participate in all school activities and Physical Education? Yes  No

If no, please explain. \_\_\_\_\_

3. Does your child have any chronic illnesses or disabilities? Yes  No

If yes, please explain \_\_\_\_\_

4. Is your child currently taking any medication on a regular basis, other than malaria prophylaxis? Yes  No

5. If yes, please list medications and state reason for taking them:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_

I verify that all the information provided is correct:

Signature (parent/guardian): \_\_\_\_\_ Date: \_\_\_\_\_