INTERNATIONAL SCHOOL MANILA

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Student Health Card and Physical Examination Record

This Health Card and the Physical Examination Record must be on file at the School Health Clinic on the date the student enters school. The child's School Office must be notified of a guardianship anytime that parents leave Manila without their children.

Photo
3 x 4 cm

FOR OFFICE USE:

SCHOOL YEAR/ GRADE/ AGE

_____

The information on this form will be treated as confidential and will only be shared with school personnel on a need-to-know basis.

STUDENT ID# _____

IMPORTANT: PARENTS MUST FILL OUT THE INFORMATION REQUESTED BELOW (IN PRINT) AND COMPLETE PAGES 2-3 OF THIS FORM. PAGE 4 MUST BE COMPLETED BY A LICENSED PHYSICIAN NO MORE THAN 12 MONTHS BEFORE EXPECTED START DATE.

Student and Family Information

Student's Name: _____ ***Preferred Name:*** _____
Family Name *First Name* *Middle Name*

Gender: M / F ***Date of Birth:*** _____/_____/_____ ***Nationality:*** _____
mm dd yyyy

Student resides with: ❑ **Both Parents** ❑ **Father** ❑ **Mother** ❑ **Guardian**

FATHER / GUARDIAN'S NAME:	***MOTHER / GUARDIAN'S NAME:***
_____	_____
Home Address: _____	***Home Address:*** _____
_____	_____
Home Phone #: _____	***Home Phone #:*** _____
Mobile Phone #: _____	***Mobile Phone #:*** _____
Direct Office Line #: _____	***Direct Office Line #:*** _____
Office Phone #: _____	***Office Phone #:*** _____
Company Name: _____	***Company Name:*** _____
Languages Spoken: _____	***Languages Spoken:*** _____

For Emergency (If Parents Cannot Be Reached)*

****Domestic helpers do not qualify as guardians, regardless of the student's age.***

Primary Contact: _____ ***Phone #:*** _____ ***Mobile #:*** _____

Secondary Contact: _____ ***Phone #:*** _____ ***Mobile #:*** _____

Local Doctor or Health Care Provider: _____ ***Phone #:*** _____

NOTE: Please notify the Admissions Office of any changes in phone numbers or contact persons.

MEDICAL INFORMATION and HEALTH HISTORY

1) ***Allergies?*** ❑ **No** ❑ **Yes** ***What is the allergy to? (foods, drugs, etc.)*** _____

Reaction: _____

If yes, is there history of severe allergy or anaphylactic reaction? ❑ No ❑ Yes

Does the student carry an AAI (adrenalin auto-injector, e.g. Epipen)? ❑ No ❑ Yes

Please obtain the Anaphylaxis Management Form from the Health Clinic/ ISM website and see the Clinic Administrator.

2) ***History of serious respiratory reaction to a food, bee sting or a drug?*** _____

3) ***Asthma?*** ❑ No ❑ Yes ***Does the student carry an asthma inhaler?*** ❑ No ❑ Yes

4) ***Is the student on regular medication:*** ❑ No ❑ Yes

Name of the medication/s and frequency: _____

Does the student need to take any medication/s during school hours? ❑ No ❑ Yes
(If so, a letter from the Medical Doctor must be kept on file in the Health Clinic and the medication/s kept in the Clinic to be dispensed by the School doctor or nurse.)

5) **Does the child have any present illness:** ❑ No ❑ Yes

Describe: _____

Health History:

Please indicate if your child has had any of the following conditions. If the answer is yes to any, please give details below.

	No	Yes	Age		No	Yes	Age
Diabetes				**Scoliosis**			
Meningitis				**Skin Diseases**			
Tuberculosis				**Psoriasis**			
Fainting Spells				**Vitiligo**			
ADD / ADHD				**Atopic Dermatitis**			
Heart Disorder				**Impetigo**			
Urinary Disorder				**Other Illness/Condition**			
Epilepsy							

Describe: _____

Hospitalization, Serious Injuries/Illness?(Please give details.) _____

Eye glasses or contact lenses: ❑ **No** ❑ **Yes**

Eye or vision problems, describe: _____

Hearing problem(s)/ multiple ear infections: ❑ **No** ❑ **Yes**

Describe: _____

IMMUNIZATION RECORD

To be filled in by parents. Please attach or complete schedule below, including dates for childhood vaccinations.

TYPE	DATE	DATE	DATE	DATE	DATE
The following immunizations are mandatory and must be current before a student may enter class.					
DPT / DT	2 mo*:	4 mo*:	6 mo*:	15-18 mo*:	4-6 yrs*:
Polio	2 mo*:	4 mo*:	6-18 mo*:	4-6 yrs*:	
Measles	12-15 mo*:	4-6 yrs*:			
Mumps	12-15 mo*:	4-6 yrs*:			
Rubella	12-15 mo*:	4-6 yrs*:			
The following immunizations are strongly recommended.					
Tetanus booster (between ages 12 – 15)					
Hepatitis A					
Hepatitis B					
Varicella (chickenpox)					

* Recommended international standard

TUBERCULOSIS SCREENING CHECKLIST

Do any of the following conditions or situations apply to you or your child?

a) A persistent cough (three weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? YES ☐ NO ☐

b) Lived with or been in close contact to a person known to be or suspected of being sick with TB? YES ☐ NO ☐

c) Lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? YES ☐ NO ☐

If the answer to any of the above is **YES**, please see Tuberculosis Screening Section on page 4.

AUTHORIZATION

I give consent for my child to receive the following:

***1. Minor first aid (at the clinic)** YES ☐ NO ☐

***2. Emergency care (at the clinic)** YES ☐ NO ☐

***3. Emergency care (at hospital Emergency Room)** YES ☐ NO ☐

4. Oral non-prescription medication YES ☐ NO ☐

NOTE:** ***If "NO" to 1,2, and/or 3 above, the student may not enter school until a meeting is set with the School Health Clinic.

I hereby authorize the ISM designated Dentist to give the following dental treatment to my child, as the need arises:

Emergency dental examination YES ☐ NO ☐

Emergency dental treatment YES ☐ NO ☐

Permission is hereby given for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

I certify that all information given on this card is complete and correct.

I acknowledge that it is my responsibility to inform the ISM School Health Clinic of any changes in my child's health, physical condition or medical needs.

In order to comply with a new government law on data privacy, we are now obliged to ask for parents' permission to collect, process and store all personal data. When you tick the box below, you are giving formal consent for this to happen.

○ **Yes – I give my consent to ISM to process my personal information and sensitive personal information for the purpose(s) described in the ISM Privacy Policy found in www.ismanila.org > About Us > Information Technology.**

○ **No – I do not give my consent to ISM to process my personal information and sensitive personal information for the purpose(s) described in the ISM Privacy Policy found in www.ismanila.org > About Us > Information Technology. I understand that this effectively rescinds my application.**

Parent's Name: _____

Parent's Signature: _____ Date: _____

PHYSICAL EXAMINATION – *To be completed by a Licensed Physician.*

This form is mandatory for school admission and must be completed no more than 12 months before expected start date.

Height (cm) _____ Weight (kg) _____ Blood Pressure _____ Vision: R _____ L _____ Both _____ Blood type _____

Please review the following areas:	Normal	Findings	DESCRIPTION (Attach additional sheets if necessary)
1. Head, Eyes, Ears, Nose, Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Genitourinary			
7. Musculoskeletal			
8. Metabolic/Endocrine			
9. Neuropsychiatric			
10. Skin			
11. Mammary			

Describe Findings: _____

_____

Comments: _____

_____

An ECG (12-lead resting electrocardiogram) is REQUIRED for all new students entering Grade 6 and above.

Diagnosis: ❑ **age appropriate ECG** ❑ **further cardiological diagnostic required** ❑ **pathological heart condition**

Findings: _____

If further tests are required, please submit findings along with this form.

Remarks: _____

TUBERCULOSIS SCREENING

ATTENTION HEALTH CARE PROVIDER: Please refer to the Tuberculosis Screening Checklist on page 3. If the answer to any of the questions is YES, proof of PPD skin test is required. If the student has a history of a positive PPD test or if PPD result is positive a chest x-ray is REQUIRED. PPD and/or chest x-ray must be done within one calendar year prior to admittance. History of BCG vaccination does not exclude the student from PPD skin testing.

PPD Skin Test

Date Given: _____ mm diameter: _____	Date Read: _____ Test Result: _____

CHEST X-RAY

Required for those with a positive skin test, history of a positive skin test or history of tuberculosis infection.

Date of x-ray: _____	Result of x-ray: _____

If negative CXR and positive PPD, did student complete a course of treatment? YES ☐ NO ☐
If yes, how many months did the treatment last? _____ (# of months)

Physician's Printed Name **Signature and Title** **License Number** **Date**

Address **Office Phone Number**