

HEALTH RECORD MARYMOUNT INTERNATIONAL SCHOOL

This form must be completed accurately by both a parent/guardian and a physician before the child may attend school. A new Health Record form must be completed when moving between Early Childhood, Elementary School, Middle School, and High School. Some medical conditions might require more specific and frequent health assessment depending on the child's individual condition.

Please use BLOCK capitals

Name of student _____ Grade entering _____
Family First Middle

Date of Birth _____ **Sex:** M ___ F ___ **Nationality** _____
Day/month/year

MEDICAL HISTORY:

Does your child have or ever had any of the following:

Seizure Disorder: Infantile convulsions _____ Febrile convulsions _____ Epilepsy _____

Asthma _____ Diabetes _____ Migraine _____

If YES, please explain: _____

Any Allergies to medication, insect bites, food, environment? Yes _____ No _____

If YES, please indicate type of allergy and treatment needed: _____

Any dietary requirements? Yes _____ No _____ If YES, please state requirements: _____

Please explain any significant medical conditions of which the school should be aware: _____

Does your child:

Wear glasses or contacts? _____ Have hearing problems? _____

Take medication on a regular basis? _____

Has your child ever been hospitalized or undergone surgery?

Is your child currently undergoing professional counseling/therapy? If YES, please explain: _____

In case of a medical emergency I understand that all efforts will be made to contact the parents/guardian. If unsuccessful, I authorize the school to give or obtain the necessary medical attention.

In case of emergency and the parent/guardian is not available please contact: Name: _____

Home Telephone: _____ Mobile Telephone: _____

As a responsible parent I authorise / I do not authorise the school nurse to divulge to the appropriate faculty/staff member any details pertaining to my child when the nurse in her professional capacity is of the opinion that it would be to the benefit of the child within the framework of the applicable Italian law.

Parent/Guardian Signature: _____ **Date:** _____

IMMUNIZATIONS Please fill in the chart below:

You may submit a copy of your child's immunization booklet, or complete the dates administered below:

At age	Immunization	Date
3 months of age	1 st anti Hepatitis B	
	1 st dose DTPa Diphtheria / Tetanus / Pertussis	
5 months of age	1 st dose Polio	
	2 nd anti Hepatitis B	
	DTPa Diphtheria / Tetanus / Pertussis	
11-12 months of age	Polio	
	3 rd anti Hepatitis B	
	DTPa Diphtheria / Tetanus / Pertussis	
12-15 months of age	MMR Measles, Mumps and Rubella	
3 years	4 th polio	
4-6 years	DTPa and Measles, Mumps booster	
11-15 years	DT booster and every 10 years thereafter	
	Chicken Pox vaccine	

Insurance Policy Number: _____

Medical Italian ASL Number: _____

PHYSICAL EXAMINATION: to be completed and signed by a *licensed physician*

Height: _____ Weight: _____ Heart: _____ Heart Rate: _____

Nose: _____ Mouth: _____ Teeth: _____ Lungs: _____

Skin: _____ Abdomen: _____

Scoliosis: _____ Reflexes: _____

Hearing: _____ Vision: _____

Development: _____ Menstrual History: _____

General Appraisal/Comments: _____

I hereby certify that this student is physically fit to partake in sports activities connected with Marymount International School.

Doctor's Name: _____ **Tel:** _____

Doctor's Signature/Stamp: _____

Date: _____