



International School of Port of Spain

STUDENT HEALTH RECORD FOR REGISTRATION

Name _____ M F
(LAST) (FIRST) (MIDDLE)

Date of birth _____ Grade entering this year _____
MONTH DAY YEAR

Parent's/Guardian's name _____

Address _____
NUMBER AND STREET CITY STATE ZIP/POSTAL CODE

Home telephone no. _____ Cellular phone no. _____ Office telephone no. _____

In case of emergency call _____ Telephone: _____

Physician's name _____ Telephone: _____

In case of emergency, I authorise the school to use its judgment, if no authorised person listed above can be reached

SIGNIFICANT MEDICAL HISTORY

Disease/Condition	Date
Measles	
Asthma	
Cardiac Murmur/Rheumatic Fever	
Diabetes	
Encephalitis	
Head Injury/Concussion	
Intestinal Parasites	
Malaria	
Nephritis	
Tuberculosis	
Ulcer	
ADD/ADHD	
Whooping Cough	
German Measles	
Hepatitis	
Scarlet Fever	
Mumps	
Chicken Pox	
Diphtheria	

Vaccination/Immunization	Date
Chicken Pox	
Diphtheria	
Hepatitis 'B'	
Measles, Mumps, Rubella (MMR)	
Meningitis	
Polio	
Tetanus	
Typhoid	
Whooping Cough	
Yellow Fever	

Vision			
Date	R	L	Pass/Fail

Hearing			
Date	R	L	Pass/Fail

Mantoux			
Date	R	L	Pass/Fail

Please turn over for more information

STUDENT HEALTH RECORD FOR REGISTRATION *continued*

Allergies (Please specify if your child has specific medication and send it with dosage noted) _____

Surgery (Specify type and give date) _____

Emotional or mental patterns of which the school should be aware of (Phobias, Anxieties, etc.) _____

Ethnic s/Nutritional/Religious customs (helpful for field trips) _____

Most recent physical exam _____

Medication taken at home or at school _____

Restrictions on Physical Activity _____

My child may be given an analgesic, if necessary (specify) _____

BLOOD TYPE _____ Group _____ Rho _____

COMMENTS _____

Signature of Parent or Guardian _____



International School of Port of Spain

CONSENT FOR “OVER THE COUNTER” MEDICATIONS

Name of student _____
(LAST) (FIRST) (MIDDLE)

Date of Birth _____ Grade _____
MONTH DAY YEAR

Medication Allergies _____

Medications your child takes on a regular basis _____

I give permission for my child, _____, to receive any medication I have indicated here below as deemed necessary by the school nurse. I understand that generic equivalent medications may be used in place of brand-name items.

PLEASE CHECK ANY “OVER THE COUNTER” MEDICATIONS YOU WISH TO BE MADE AVAILABLE TO YOUR CHILD UNDER NURSING DISCRETION, DOSAGE DETERMINED BY AGE AND/OR WEIGHT

For headache/fever/muscle aches, menstrual cramps

- Acetaminophen (like Tylenol)
- Ibuprofen (like Advil, Motrin) – best for menstrual cramps, muscle/bone pain,
- orthodontic pain – Liquid (100mg/5mls) and 200 mg tablets

For mild allergic reactions (such as hives, seasonal allergies)

- Benadryl liquid (12.5 mg/5ml)

For mild cold symptoms

- Robitussin DM cough medicine
- cough drop
- throat lozenge

For mild stomach discomfort

- Antacid (1-2 tabs)

For mild skin irritation (insect bites, minor rashes, abrasions)

- Calamine lotion
- Hydrocortisone cream 1%
- Bacitracin ointment

I do not want any medication given to my child in school

I understand that the above medications I have checked will be administered by the school nurse, or her designee.

Year _____
INITIAL DATE CHILD'S WEIGHT

Signature _____