THE INTERNATIONAL SCHOOL OF PORT OF SPAIN

CONFIDENCE EXCELLENCE INTEGRITY

1 International Drive, Westmoorings, Trinidad and Tobago, W.I.
Phone: 1(868)-633-4777, Fax: (868) 632-4595, Web: www.isps.edu.tt

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

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	

Please attach a copy of any vaccination/ immunization records or complete the table below.

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

Allergies: _____

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

Surgery _____
(Specify type and give date)

_____

STUDENT HEALTH RECORD FOR REGISTRATION *continued*

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

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

Most recent physical exam _____

Medication your child takes on a regular basis _____

Restrictions on Physical Activity _____

BLOOD TYPE _____ Group _____ Rho _____

COMMENTS _____

CONSENT FOR "OVER THE COUNTER" MEDICATIONS

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,
- ☐ Paracetamol

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

- ☐ Genetics Allergy Syrup / Benadryl liquid

For mild cold symptoms

- ☐ cough drop ☐ throat lozenge

For mild stomach discomfort

- ☐ Antacid (1-2 tabs)

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

- ☐ Calamine lotion ☐ Antihistamine 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 CHILD'S WEIGHT

Signature _____ _____

DATE