HERITAGE INTERNATIONAL SCHOOL
Student Health Record

Confidential
Complete one per student.

Child's Name: _____

Date of Birth: _____ Grade: _____ Sex: M F (circle one)

Is child's health excellent, fair or poor? _____ Weight: _____ Height: _____

ALERT TO PARENTS: If your child has a serious medical condition, **it is vital that you discuss this with your School Nurse and teacher(s) immediately.** The school **must** know of **LIFE THREATENING** conditions (for example severe allergy with anaphylaxis, diabetes, asthma) prior to the start of school. In order to provide a safe and healthy environment for your child this information will be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

MEDICAL HISTORY

Check the ones that apply and describe under the comment section.

_____ ADD/ADHD
_____ Anxiety/Panic attack
_____ Asthma * see below
_____ Kidney/urinary
_____ Bowel problem
_____ Cerebral Palsy
_____ Color Blindness
_____ Epi-Pen
_____ Emotional Concerns
_____ Headaches
_____ Hearing Problem
_____ Heart Condition
_____ Muscle Disorder
_____ Neurological Concern
_____ Diabetes
_____ Orthopedic problem
_____ Seizures
_____ Vision problems other than corrective lenses
_____ Other: _____

_____ **PE activity**
Not Limited ____
Limited ____

Comments: _____

List any health or social issues which you or your family physician feel should be known to the school administration:

_____

ASTHMA

*If you checked Asthma above please answer:

Does your child take **daily** asthma prescription medicine?	Yes / No
Does your child take more than 2 asthma medications daily?	Yes / No
Has your child been to the ER for asthma in the past 12 months?	Yes / No
Has your child used steroids in the past year for asthma symptoms?	Yes / No
Does your child have asthma symptoms more than 3 days a week?	Yes / No
Do asthma symptoms interfere with sleep?	Yes / No

ALLERGIES

Does your child have any known allergies? Yes / No
If so, please list below:
Any FOOD allergies: _____
Any allergies to WASPS, BEES or other INSECT bites: _____
Any DRUG allergies: _____

⌖All medications should be left in the nurse's office with specific instructions.⌖

SURGERY

Has your child ever had any minor or major surgery? Yes / No

If so, please give the type and date:

Type of surgery: _____

Date of surgery: _____

DENTAL

Does your child have any dental needs or prosthesis? Yes / No

If so, please explain: _____

Name of Dentist: _____

GLASSES

Does your child wear prescription lenses? Yes / No Glasses or Contact lens? (circle one)

If so, what is the date of his/her last eye examination?

HEARING

Has your child ever had a professional hearing test? Yes / No Date: _____

Any treatment necessary? Yes / No

OTHER HEALTH INFORMATION

Has your child ever had any kind of psychological examination? Yes / No Date:

Any treatment necessary? Yes / No

Date your child had last tuberculin test. _____ Results: _____

Is your child presently under medical treatment? Yes / No Blood Type: _____

I certify the above history is complete to the best of my knowledge.

_____ _____

Parent's signature Date

Authorization of Non-Prescription Medication

The staff of Heritage International School has my permission to administer the following if needed to my child:

	Yes	No	Please call me beforehand	Initials
Paracetamol	_____	_____	_____	_____
Ibuprofen	_____	_____	_____	_____
Antihistamine	_____	_____	_____	_____
Antacid	_____	_____	_____	_____
Topical Neosporin	_____	_____	_____	_____

_____ _____

Parent's Signature Date

Authorization for Emergency Medical Care

(One Per Student)

Emergency Medical Policy:
In case of emergency illness or accident the child is given first-aid and the parents are notified. If the parents cannot be located, the child will be taken to the International Hospital, Kampala. Heritage International School does not assume responsibility for the payment of hospital, doctor or transportation fees.

In the event I cannot be reached to make arrangements for emergency medical care at the time of an accident or illness, I hereby authorize Heritage International School to take my child to International Hospital Kampala or _____. If no hospital is specified, my child will be taken to IHK.

_____ _____

Child's Name Grade

_____ _____

Parent's Signature Date

Insurance Waiver

Heritage International School has liability insurance, which will pay for medical costs (up to predetermined limits) if your child is injured while at school, at any school related activity, or while being transported on school vehicles.

I understand that Heritage International School will not be held responsible for any injury that occurs involving my child(ren). The school's liability insurance will pay for medical costs up to the designated limits, and I will not expect Heritage International School to pay damages beyond that.

** Any incomplete or false information written above will result in non coverage of health insurance.**

_____ _____

Parent's Signature Date