Health Record

This form must be completed and on file in the nurse's office when the student enters school.This enables us to adequately care for your child during the school day.

Name of Student (Last/First/Middle) | Nationality

Date of Birth (Day/Month/Year) | Sex (Male/Female) | Grade

Parent/Guardian

Address in Germany | Telephone (Home)

Telephone (Business)

Mobile (Mother) | Mobile (Father)

Email

Emergency Contact | Telephone

Health Insurance Group | Name & Phone Number of Family Physician in Germany

1. **Allergies:** List allergies your child has. Include foods, drugs, plants, animals. ☐ None

Cause | Reaction | Treatment

Cause | Reaction | Treatment

2. **Medication:** Does your child take medication at home on a daily basis? ☐ No ☐ Yes

Medication | Used to treat | Dose/Time

Medication | Used to treat | Dose/Time

Before daily medication can be administrated by the nurse, a "Medication Administration Form" available from the nurse's office MUST be completed by the parent or guardian.

3. **Treatment:** Is your child receiving current or ongoing treatment for any medical, surgical or psychological condition? ☐ No ☐ Yes

If yes, please explain and attach physician's statement.

4. **Sports Participation:** Is there any reason why your child cannot participate in Physical Education classes or in intramural/interscholastic sports? No Yes

If yes, please explain and attach physician's statement.

5. **Visual Difficulties:** ☐ No ☐ Yes ☐ Glasses ☐ Contact Lenses

Health Record

6. Special Needs: Any previous difficulties with hearing, speech or language development? ☐ No ☐ Yes

If yes, please give details

7. Diseases: Please indicate (√), if your child has had the following diseases:

☐ Chicken Pox ☐ Smallpox ☐ Poliomyelitis ☐ Hepatitis ☐ Diphtheria
☐ Tuberculosis ☐ Rheumatic Fever ☐ Mumps ☐ Scarlet Fever ☐ Whooping Cough
☐ German Measles ☐ Frequent Ear Infections/Colds

8. Immunizations: Please provide month and year of immunizations received and attach a copy of the original record.

Tuberculosis-BCG _____ MMR (Measles, Mumps, Rubella) _____

Hepatitis B _____ Poliomyelitis _____

DPT (Diphtheria, Pertussis, Tetanus) _____ Date of last X-ray _____

9. Conditions: Please indicate (√), if your child has had the following conditions:

☐ Seizures ☐ Headache ☐ Blood Pressure ☐ Eczema ☐ Frequent Nosebleeds
☐ Asthma ☐ Physical Disabilities ☐ Emotional ☐ Other: _____

10. Other Medical/Health Information: major illnesses, injuries, operations you may wish to include that may help us understand your child's health needs:

11. Medical Permission: I hereby give permission for my child to be given temporary medication by the school nurse. Medication used in the nurse's office may include, but is not limited to Paracetamol, Ibuprofen, and some homeopathic remedies.

Signed Date

12. Accident Treatment Permission: I understand all efforts will be made to contact parents first, emergency contact second and if neither are available I hereby give permission for emergency measures to be initiated in case of accident or sudden illness. I certify that all information given is correct and complete.

Signed Date

Failure to declare accurate and full medical information may result in annulment of the school's acceptance offer or require withdrawal from ISH.

Medication Administration

Name of Student (Last/First/Middle)

Grade

Teacher

Diagnosis

Medication

Time to be given

Duration of Medication

Any other instructions

Signed

Date

Hemmingstedter Weg 130 • 22609 Hamburg • Germany • Phone: +49 (0) 40 8000 50 0 • Fax: +49 (0) 40 881 1405 • info@ishamburg.org • www.ishamburg.org