

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)	
Email	Mobile (Father)	
Emergency Contact	Telephone	
Health Insurance Group	Name and Phonenumber 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



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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:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> 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:

- | | | | | |
|-----------------------------------|--|---|---------------------------------------|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Headache | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Eczema | <input type="checkbox"/> Frequent Nosebleeds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Physical Disabilities | <input type="checkbox"/> Emotional | <input type="checkbox"/> 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 FORM

ISH · Hemmingstedter Weg 130 · D-22609 Hamburg

Name of Student (Last/First/Middle)

Grade

Teacher

Diagnosis

Medication

Time to be given

Duration of Medication

Any other Instructions

Signed

Date

