HEALTH ASSESSMENT FORM

***Both sides must be filled out before admission**

NOTE: this form will be used in the nurse's office.

PLEASE FILL OUT COMPLETELY

AMERICAN SCHOOL OF MILAN

Student's Name: ______________________________ Sex: ___ Age: ___ Grade: ____ Date of Birth: _____/_____/_____
Last First DD MM YY

Father's Name: __________________________ Home Tel. No. ______________ Business Tel. No. ______________

Mother's Name: __________________________ Home Tel. No. ______________ Business Tel. No. ______________

EMERGENCY CONTACT (if parents cannot be reached) ________________________ Tel. No. ______________________

HEALTH HISTORY (to be completed by parents, giving approximate dates)

Asthma ______________________________

Allergies-Drug/Insect/Environment/Food ______________

Orthopaedic Handicap ______________________

Hearing Loss __________________________

Blood Disorder __________________________

Muscular Disorder ________________________

Intestinal Disorder ________________________

Kidney Disorder __________________________

Neurological Disorder ______________________

Seizure Disorder __________________________

Cardiac Disorder __________________________

Rheumatic Fever ______________________________

Scarlet Fever ______________________________

Chicken Pox ______________________________

Measles (type) ______________________________

Whooping Cough ______________________________

Mumps ______________________________

Meningitis ______________________________

Polio ______________________________

Diabetes ______________________________

Hepatitis (state which type) ______________________

Mononucleosis ______________________________

Other Illness ____

List hospitalisation and operations, give dates: ____

Impaired vision? __________________________ Wear glasses or contacts __________________________

Is or was student under care of Psychiatrist/Psychologist/Counsellor (give dates)? ______________________

Has student had any referrals to medical specialist? (reason & dates) ______________________________

Is student able to participate in full Physical Education Program YES / NO?
If NO, please include a letter from your family physician giving details. ______________________________

Does your child take medication (if yes, state name or type)? ______________________________________

Any medication (prescription or on non-prescription) that needs to be given by the school nurse requires a doctor's written authorization. ____

IMMUNIZATIONS (give dates and include a copy of student's completed immunization record)

D.T.P. Series __________________________

Polio Series __________________________

Hepatitis B __________________________

MMR ___ __________________________

Tuberculin Test ________________________

HIB ______________________________

Booster ______________________________

Booster ______________________________

Booster ______________________________

Booster ______________________________

Result ______________________________

Others (Chicken Pox Vacc.) ____________________

I AUTHORIZE SCHOOL PERSONNEL TO OBTAIN EMERGENCY MEDICAL CARE FOR MY CHILD IN THE EVENT I CANNOT BE REACHED. IF TRANSPORTATION BY AMBULANCE IS REQUIRED, THIS MAY BE OBTAINED.
I FURTHER AUTHORIZE THE SCHOOL NURSE TO SHARE NECESSARY INFORMATION WITH ASM STAFF AS NEEDED.

Date _____/_____/_____ Signature of Parent or Guardian ______________________________

PHYSICAL EXAMINATION

(to be completed by licensed Physician) before admission and every 3rd year in the school)

Name of Child ______________________________ Birth Date ____/____/____
Last First DD MM YY

Name of Parent or Guardian ______________________________

Home Address ______________________________
Street City Zip Pr.

Eyes & Vision ____________________

Hearing ____________________

ENT ____________________

Oral Cavity ____________________

Cardiovascular System ____________________

Respiratory System ____________________

Muscular Skeletal System ____________________

Nervous System ____________________

Abdomen ____________________

Skin ____________________

Thyroid ____________________

Speech/Language ____________________

Are immunizations, boosters or re-vaccinations indicated? ______________________________

Vision: Does the child wear glasses? __________ Is there a family history of visual defects? __________

Hearing: Does the child have any history of hearing loss, draining ears or frequent ear infections? __________

Pertinent family history: ______________________________

Is child receiving on-going medical care? ______________________________

Does the child need medical care? ______________________________

Does any irremediable defect exist? ______________________________

Are there problems of behaviour, growth and development, nutrition with which teachers should be acquainted?

____

____

Any past injuries or operations? ______________________________

Should the school contact you for a more complete report? ______________________________

Does this child take prescription medicine? (If so, what?) ______________________________

Significant findings and physician's recommendations to parents and teachers: ____________________

____

____

Recommendations for Physical Education: Full Program ( ) Restricted ( ) explain: ____________________

____

Can this child participate in our Varsity Sports program? ______________________________

Additional Data: ______________________________

____

Date ____/____/____ Physician's signature and stamp ______________________________ MD