ASM AMERICAN SCHOOL OF MILAN

HEALTH ASSESSMENT FORM **page 1 must be filled by parents, page 2 must be filled by licensed physician before admission and every third year in the school. PLEASE FILL OUT COMPLETELY.** NOTE: this form will be used in the nurse's office.

Student's Name: _____ Sex: ___ Age: ___ Grade: ____ Date of Birth: _____/_____/_____
Last First DD M M 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 _____ Rheumatic Fever _____
Allergies-Drug/Insect/Environment/Food _____ Scarlet Fever _____
Orthopedic Handicap _____ Chicken Pox _____
Hearing Loss _____ Measles (Rubeola) _____
Blood Disorder _____ Rubella _____
Muscular Disorder _____ Whooping cough (pertussis)_____
Intestinal Disorder _____ Mumps _____
Kidney Disorder _____ Meningitis (state which type) _____
Neurological Disorder _____ Polio _____
Seizure Disorder _____ Diabetes _____
Cardiac Disorder _____ Hepatitis (state which type) _____
Mononucleosis _____ Other Illness _____
List hospitalization and operations, give dates. _____
Impaired vision? _____ Wear glasses or contacts _____

Is or was student under care of Psychiatrist/Psychologist/Counselor (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 (Diphtheria, Tetanus and Pertussis)*_____ Booster _____
Polio Series* _____ Booster _____
Hepatitis B* _____ Booster _____
MMR (Measles, Mumps, Rubella)*_____ Booster _____
Meningitis B _____ Booster _____
Meningitis C _____ Booster _____
HIB (Haemophilus Influenzae B)* _____ Booster _____
Chicken Pox* _____ Booster _____
Other:_____ _____

**Mandatory Vaccinations in Italy D.L. June 7th 2017, n. 73*

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 _____
Ears, nose, throat _____
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 illness/handicap 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 Competitive Sports program? _____
Additional Data: _____
_____

Date _____/_____/_____ Physician's signature and stamp _____ MD