**NATIONALHIGH**

JAKARTA SCHOOL

**HEALTH CARD & EMERGENCY INFORMATION** i

This card must be completed and submitted for filing to the health center on the child's first week of school. Please fill the information below.

Male/Female

Student's Name : Click or tap here to enter text.

Date of Birth : Click or tap here to enter text.

Name of Parent (s) : Click or tap here to enter text.

Home Address : Click or tap here to enter text.

Mobile Phone : Click or tap here to enter text.

Home Phone : Click or tap here to enter text.

Office Phone : Click or tap here to enter text.

Office Address (F) : Click or tap here to enter text.

Office Phone : Click or tap here to enter text.

Office Address (M) : Click or tap here to enter text.

**NOMINATED EMERGENCY CONTACTS (Non parents in Jakarta known to the child)**

1. Name :Click or tap here to enter text. Mobile Phone : Click or tap here to enter text.

Home Phone : Click or tap here to enter text.

2. Name :Click or tap here to enter text. Mobile Phone : Click or tap here to enter text.

Home Phone : Click or tap here to enter text.

**DOCTOR NAME AND CLINIC : …………………………………………………………………………………………….**

Address : Click or tap here to enter text.

Phone : Click or tap here to enter text.

**INFORMATION WHICH MAY BE CRUCIAL IN THE HANDLING OF AN EMERGENCY**

Allergies : Click or tap here to enter text.

Drug Reaction: Click or tap here to enter text.

Date of most recent Tetanus shot: Click or tap here to enter text.

Wear glasses *I* contact lenses: ……………………………………………………………………………………YES *I* NO Is the student on medication? ……………………………………………………………………………………. YES *I* NO If YES, Please list the name of medication and frequency: Click or tap here to enter text.

**THE FOLLOWING HEALTH CONDITION CAN BE OF CONCERNED**

**PLEASE CIRCLE ANY THAT APPLIED**

Allergies, asthma, congential anomalies, convulsions/epilepsy, diabetes, recurring ear infections, hearing difficulties, frequent headaches, heart problems, kidney/urinary infection, menstrual problems, orthopedic problems, post operatic condition, rheumatic fever, skin problem, tuberculosis, visual problems, others (please mention).

Please comment on any circled items.

Click or tap here to enter text.

Has your child ever had any operation?..................................................................................................YES I NO What kind and when? Click or tap here to enter text.

Explain any limits of physical activity: Click or tap here to enter text.

**IMMUNIZATION RECORDS (Please attach copy of the records)**

Please provide country of citizenship: Click or tap here to enter text.

And dates of immunizations :

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Date | Date | Date | Date | Date |
| OPT |  |  |  |  |  |
| DT |  |  |  |  |  |
| Polio |  |  |  |  |  |
| MMR |  |  |  |  |  |
| HB |  |  |  |  |  |
|  | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Date | Date | Date | Date | Date |
| Rubella |  |  |  |  |  |
| Typhoid |  |  |  |  |  |
| HepA |  |  |  |  |  |
| Hep B |  |  |  |  |  |
|  | | | | | |

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**JAKARTA SCHOOL**

**STATEMENT**

I will inform the school of any changes of these details, in the event of an accident, if neither I nor my emergency contact cannot be reached, I authorize the principal, or whoever he authorizes, to initiate emergency medical

procedures deemed necessary.

Parent's Signature \_\_\_\_\_\_\_\_

Y.OUR CHILD"S HEALTH

Please complete this information sheet. This will allow the School Nurse to not on y advise you on any concern, but also provide support for your child should there be a need now or in he future.

**The information you will give be entirely confidential and will not be release without your permission.**

Name of Child Click or tap here to enter text.

Class Click or tap here to enter text.

Date of Birth Click or tap here to enter text.



Other children in the family: please write the name of the sibling and add date of birth

1. Name of sibling Click or tap here to enter text. Date of Birth Click or tap here to enter text.

Name of sibling Click or tap here to enter text. Date of Birth Click or tap here to enter text.

2. Does s/he have frequent earaches, ear infections, hearing difficulties?...................................... YES *I* NO

3. Does s/he have eye trouble of any kind squint/lazy eye/wear glasses?...................................... YES *I* NO

4. Does s/he have frequent trouble with speech?............................................................................ YES *I* NO

5. Does s/he have bad teeth?.......................................................................................................... YES *I* NO

6. Does s/he have frequent colds, nose bleed, sore throats, cough, wheezing or breathlesness... YES *I* NO

7. Does s/he get tired very easily get blue around the lips?............................................................ YES *I* NO

8. Does s/he ever have severe headache?..................................................................................... YES *I* NO

9. Does s/he have fainting attacks, blackouts, convulsions or fits of any kind?............................... YES *I* NO

10. Does s/he have pains or burning passing urinate or pass urine much more often than other children?

................................................................................................................................................... YES *I* NO

11. Does s/he wet her/him self during the day/night?...................................................................... YES *I* NO

12. Does s/he tend to have frequent loose motions/constipations/other tummy trouble................. YES *I* NO

13. Does s/he soil her/him self during the day/night?...................................................................... YES *I* NO

14. Do you thinks/he very much overweight/very much underweight?........................................... YES *I* NO

15. Iss/he on a special diet?........................................................................................................... YES *I* NO

16. Has s/he anything wrong with her/his bones or joints?............................................................. YES *I* NO

17. Does s/he limp/stand badly/have trouble with feet?.................................................................. YES *I* NO

18. Does s/he have any skin trouble?............................................................................................. YES *I* NO

19. Does s/he often have nightmares, night terrors, twitches, sleepwalking, etc?.......................... YES *I* NO

20. Iss/he particular timid/anxious child/cries a lot for no reason/has frequent tantrums?............. YES *I* NO

21. Iss/he unhappy at school/a poor mixer/picked a lot by other children?.................................... YES *I* NO

22. Is s/he having a lot of difficulty in keeping up with her/his lessons?.......................................... YES *I* NO

23. Does s/he have any allergies?................................................................................................... YES *I* NO

24. Are there any significant illnes in other members of the family (e.g: asthma, eczema, epilepsy

diabetes oe emotional distrubance?)......................................................................................... YES *I* NO If so, please give details and relationship to child:

25. Are there any matter you would like to mention?............................................................................ YES *I* NO

26. Has you child ever had educational of psychological testing?........................................................ YES *I* NO

If you have answered YES to any of the above questions, please explain:

Signature of parent/guardian ................................................................................................................................ Date ......................................................................................................................................................................