IMPORTANT: Parents must COMPLETE the information requested below (in print) and pages 2 to 3 of this form; page 4 must be completed by a licensed physician.

Dominican International School
76 Dazhi Street, Taipei (104042) Taiwan, R.O.C.
School Clinic: **25338451 ext. 119**
Email: **clinic@dishs.tp.edu.tw**

HEALTH RECORD FORM

Please paste Passport size photo here

Name of Pupil / Student (List all names as recorded in foreign passport)

Last Name *First Name* *English Name*

Grade ☐ Gender: ☐ Male ☐ Female Date of Birth ☐☐☐☐ Year ☐☐ Month ☐☐ Day

Nationality ☐ Religion ☐

Student resides with ☐ Both Parents ☐ Father ☐ Mother ☐ Guardian

	Father/Guardian *(complete information required)*	**Mother/Guardian** *(complete information required)*
Name		
Home Address		
Home Phone No.		
Mobile Phone No.		
Office Phone No.		
Company Name		
Email Address		
Languages Spoken		

FOR EMERGENCY (If Parents Cannot Be Reached)					
Primary Contact		Relation		Mobile No.	
Secondary Contact		Relation		Mobile No.	
Local Doctor		Relation		Mobile No.	

NOTE: Please notify the Admissions Office of any changes in phone numbers or contact persons.

HEALTH HISTORY

If diagnosed with any of the following, please check and provide additional information.

Allergies	❒ Yes ❒ No	If yes, please describe ❒ Foods: _____ ❒ Medicines: _____ ❒ Medication/Treatment order attached
Asthma	❒ Yes ❒ No	If yes, please describe ❒ Intermittent: _____ ❒ Persistent: _____ ❒ Medication/Treatment order attached
Seizures	❒ Yes ❒ No	If yes, specify type: _____ Date of last seizure and frequency: _____ ❒ Medication/Treatment order attached
Diabetes	❒ Yes ❒ No	If yes, specify type: ❒ 1 ❒ 2 ❒ Medication/Treatment order attached
Vision Problem	❒ Yes ❒ No	If yes, ❒ Nearsighted ❒ Farsighted ❒ Astigmatism ❒ Strabismus Please describe: _____
Hearing Problem	❒ Yes ❒ No	If yes, ❒ Hearing aid ❒ Aural habilitation ❒ Surgery Please describe: _____
Skin disease	❒ Yes ❒ No	If yes, ❒ Atopic dermatitis ❒ Eczema ❒ Others Please describe: _____
Heart disorder	❒ Yes ❒ No	If yes, please describe: _____ _____
Urinary disorder	❒ Yes ❒ No	If yes, please describe: _____ _____
Genetic disease	❒ Yes ❒ No	If yes, ❒ G6PD: Please describe: _____
Cognitive Challenge	❒ Yes ❒ No	If yes, ❒ ADD ❒ ADHD ❒ Others Please describe: _____ ❒ Medication/Treatment order attached
Fainting spells	❒ Yes ❒ No	If yes, please describe: _____ _____
Regular medication	❒ Yes ❒ No	If yes, please describe: _____ _____
Present illness	❒ Yes ❒ No	If yes, please describe: _____ _____
Surgery/Hospitalization	❒ Yes ❒ No	If yes, please describe: _____ _____
Others	❒ Yes ❒ No	If yes, please describe: _____ _____

IMMUNIZATION RECORD

To be filled out by parents. Please attach or complete schedule below, include dates for childhood vaccinations.

TYPE	Dose 1	Dose 2	Dose 3	Dose 4
Hepatitis B				
BCG				
DTap-Hib-IPV				
Pcv13				
Varicella				
MMR				
Japanese Encephalopathy vaccine				
Hepatitis A				
DTap-IPV				

AUTHORIZATION

I give consent for my child to receive the following:

1. Minor first aid (at the clinic) ☐ Yes ☐ No
2. Emergency care (at the clinic) ☐ Yes ☐ No
3. Emergency care (at hospital Emergency Room) ☐ Yes ☐ No
4. Oral non-prescription medication ☐ Yes ☐ No

I give consent for my child to participate in the following:

☐ 1. Regular program of strenuous activities and sports

☐ 2. Limited activities (Special restrictions, duration and reasons):

_____

☐ 3. No physical education or sports activities (special restrictions, duration and reasons):

_____

I hereby give permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

I certify that all information given on this form is complete and correct.

I acknowledge that it is my responsibility to inform the DIS Clinic of any changes in my child's health, physical condition or medical needs.

_____ Father / Guardian Printed Name and Signature

_____ Mother / Guardian Printed Name and Signature

_____ Date

PHYSICAL EXAMINATION - To be completed by a Licensed Physician.

Height (cm) _____ *Vision: L* _____ *Color perception screening:* ❒ Pass Hearing screening: ❒ Pass
Weight (kg) _____ *: R* _____ ❒ Fail ❒ Fail

Please review the following areas:	*Normal*	*Findings*	*DESCRIPTION (attach additional sheets if necessary)*
1. Head, Eyes, Ears, Nose, Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Genitourinary			
6. Musculoskeletal			
7. Metabolic / Endocrine			
8. Neuropsychiatric			
9. Skin (eczema, rashes)			
10. Others			

Describe Findings:_____

_____

_____

Comments (Please give details.) _____

_____

_____

_____

ASSESSMENT

I hereby certify that each examination listed above was performed by myself / under my direct supervision with the following conclusion(s)

_____	_____	_____
Physician's Printed Name	Signature and Title	License Number
_____	_____	_____
Address	Contact Numbers	Date

CLINIC STAMP