



**International
School Moshi**

Please use this box to indicate any major allergy or restriction

Day Student's Health Form

We would be grateful if you could complete this form in order to give us the medical information that we need about our students.

First Name	Family Name	Birth Date (dd/mm/yy)	Sex (M/F)
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Emergency Contact - Name:

Address:

Telephone (Office): _____ (Home): _____
 (Cell phone): _____ E-mail: _____

Medical History:

Has your child had any of the following? If YES, please write details below including dates, severity, and sensitivity:

Altitude related illness (acute mountain sickness, cerebral/pulmonary oedema)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anaemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sickle Cell Anaemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chicken Pox	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rubella	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Whooping Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Polio	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Back ache, spinal injury, disk problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cystic Fibrosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis (please indicate A, B or C)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Head injury, concussion, unconsciousness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Migraines	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting or blackouts	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mental illness (Depression, Anxiety, Phobia, Eating Disorders, Substance Abuse, other)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Respiratory tract infection (current or recent)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Knee ankle or joint injury (current or unresolved)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other serious illness, injury, operation or condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please provide details for all boxes marked YES. Please also give details of any other factors that may affect your child's physical, mental or emotional well-being. *(use another sheet if needed)*

Inoculations

Has your child been vaccinated or inoculated with any of the following? (Include dates/details as appropriate)

BCG (anti-TB)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gamma Globulin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HBV (Hepatitis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Meningitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Polio	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rabies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rubella	Yes <input type="checkbox"/>	No <input type="checkbox"/>
T.A.B.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tetanus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Triple vaccine (DPT)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yellow Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other (please specify)		

Prescription medicines required for prevention or treatment of illness or medical conditions should accompany the student as these are not always available. They should be given to the school nurse as students may not keep medicines.

Name of medicine supplied:

SIGHT: How would you describe your child's sight? Good Poor Very Weak

Does your child wear glasses? Yes No

Does your child wear contact lenses? Yes No

HEARING: How would you describe your child's hearing? Good Poor Very Weak

Does your child wear a hearing aid? Yes No

Give details of any hypersensitivities or allergies to drugs or food, etc. which you have knowledge of:	
Please indicate any particular food or dietary requirements.	
Give details of any medical reasons why your child may not be able to take part in organised school activities (such as swimming, sports, outdoor pursuits, horse riding, etc) or which might affect their performance in school:	

Parent's signature:

Date:

Note: All medicines (including malarial prophylactics), syringes, etc. are to be handed to the school nurse on arrival. Only the necessary minimum may be kept by the student with the school nurse's approval. Please attach to this form any medical details which you feel it would be helpful for the School to be aware of. Should your child develop any medical condition in future which may affect their school life, we would request that you write to give us full details. The school nurse or school doctor will give your child any medical treatment or medication that they feel necessary in the case of illness or accident and you will subsequently be informed of such treatment. Please indicate on an attached sheet any points that you wish us to note.