

STUDENT HEALTH RECORD

Student's Name: _____
 Last First M.I.

Birth Date: _____
 YYYY-MM-DD

Home Phone: _____

Email: _____

Father's Name: _____
 Last First

Father's Cell: _____

Mother's Name: _____
 Last First

Mother's Cell: _____

Father's Blood Type: _____

Mother's Blood Type: _____

Road Name / Description. (Please give directions to your home in case a school representative needs to bring your child home.)

Guardian's Name: _____

Guardian's Home: _____

Guardian's Cell: _____

Guardian's office: _____

Please list a "Release Name" if other than the guardian, who we can contact if parents are unavailable.

Release Name: _____

Release Phone: _____

Doctor: _____

Doctor's Phone: _____

Hospital: _____

Hospital Phone: _____

Medical Insurer: _____

Membership #: _____

IMMUNIZATIONS / INNOCULATION RECORDS

Please give specific dates for each immunization your student HAS received.

Diphtheria/Pertussis/Tetanus (DPT)

(*Three as an infant, booster at age 4-6, booster at age 10-12 OR within the past 5 years*)

DPT1: _____ DPT2: _____ DPT3: _____
DPT4: _____ DPT5: _____

Polio (minimum of four immunizations)

Polio1: _____ Polio2: _____ Polio3: _____
Polio4: _____ Polio5: _____

Measles/Mumps/Rubella (MMR)

(*Two usually at 12-15 months and at 4-6 years*)

MMR1: _____ MMR2: _____

Hepatitis A (series of two immunizations)

HepA1: _____ HepA2: _____

Hepatitis B (series of three immunizations)

HepB1: _____ HepB2: _____ HepB3: _____

Tetanus (Booster) _____

Typhoid: _____ Meningitis: _____

Hib (Haemophilus Influenza) _____

Chicken Pox (Varicella): _____

MEDICATIONS: Please check if you give permission to Rosslyn Academy authorized personnel to administer the following non-prescription medicine to your child if deemed necessary.

Antacid tablets <input type="checkbox"/>	Throat Lozenges <input type="checkbox"/>	Panadol/Calpol <input type="checkbox"/>
Tylenol/Acetaminophen <input type="checkbox"/>	Eye Drops <input type="checkbox"/>	Ibuprofen <input type="checkbox"/>
Piriton <input type="checkbox"/>		

MEDICAL CONDITIONS: Please check any condition that applies:

Allergies <input type="checkbox"/>	Asthma <input type="checkbox"/>	Behavior/Emotional <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Ear problems <input type="checkbox"/>	Eye problems <input type="checkbox"/>
Heart problems <input type="checkbox"/>	Speech Disorders <input type="checkbox"/>	Activity Limits <input type="checkbox"/>
Meningitis <input type="checkbox"/>	Bladder problems <input type="checkbox"/>	Bowel Problems <input type="checkbox"/>
Seizures <input type="checkbox"/>	Blood Disorders <input type="checkbox"/>	Other concerns: _____

REGULAR MEDICATIONS: Please list any medications your child takes daily or regularly

Name & Dosage: _____

*****I certify that my answers are true and complete to the best of my knowledge. All questions relating to the student have been accurately and fully answered:

Signature: _____

Date: _____