INTERNATIONAL SCHOOL OF UGANDA

Since 1967

MEDICAL & PHYSICAL INFORMATION

PLEASE WRITE IN BLOCK LETTERS

Information on Student

Name of Student - First _____ Surname _____ Nationality _____

Date of Birth (dd/mm/yy) _____ Gender M _____ F _____ Number of Children in Family _____

Name of Parents or Legal Guardians _____

Physical Home Address of Student _____

Home Telephone _____ Mobile Telephone _____

Alternative Telephone Contact in case parents cannot be contacted _____

Name and Relationship to Student _____

Name of Physician in Kampala _____ Telephone _____

Health Information

Allergies - Food /Medicine/Insects and Others _____

Chronic, Recurring Health Conditions:

Asthma Diabetes Epilepsy Sickle Cell Migraines Hepatitis

Others (Please State): _____

Other Difficulties: ADHD Visual Problems Hearing Problems

Others (Please State): _____

Has your child had any operations or hospitalization? Yes No

If Yes, please state: _____

Does your child visit a dentist at least once a year? Yes No

Does your child routinely take medicines? Yes No

If Yes, please state: _____

Does your child require emergency medication which may need to be administered in school such as Epi Pen, Asthma inhaler, allergy medication, etc.? Yes No

If Yes, please state: _____

PLEASE NOTE: Such personal medication must be provided by parents, labelled with the student's name, administration instructions and brought to the school Health Clinic on admission to ISU.

Does your child have any physical problems which would prevent him/her from participating in Physical Education classes/after-school activities/field trips? Yes No

If Yes, please state: _____

Consent to Treatment / Transfer

I agree that ISU Health Clinic nurses will, if unable to contact parents, give any treatment they deem to be necessary.

I agree that in an emergency, if my child requires urgent medical treatment and school nurses are unable to contact parents, my child will be transferred by ambulance to 'The Surgery'. I will be liable for costs associated with this ambulance transfer and subsequent treatment.

Signature of Parent _____ Date _____

For Official Use - Vaccination Record

Immunization	Dates and Doses Given				
Poliomyelitis	1	2	3	4	5
Diphteria, Tetanus, Pertussis	1	2	3	4	5
Diphteria, Tetanus	1	2	3	4	5
Tetanus: Specify Date When Last Given -					
Haemophilus Influenza	1	2	3	4	
Measles, Mumps, Rubella	1	2			
Hepatitis B	1	2	3		
Hepatitis A	1	2			
Meningitis (C or A & C)	1				
Tuberculosis (BCG)					
Yellow Fever					
Rabies					
Other					

Physical Examination Report: To be Completed by a Medical Practitioner Before Admission

Height _____ Weight _____ BP _____ Pulse _____

Nutritional Status _____ BMI _____

Vision Screening - Distance Vision - L _____ R _____ Reading - L _____ R _____

Colour Vision _____ Hearing Screening _____

Systems Examination:

_____

_____

Summary of Abnormal Findings:

_____

Recommended Treatment or Referrals:

_____

Is there any medical condition that would prevent this student from safely participating in any physical activities or field trips? Yes No

If yes, please state condition and activities to exclude:

_____

_____

Name of Physician _____ Telephone _____

Physical Address of Physician _____

Physician's Signature _____ Date _____