

**AMERICAN INTERNATIONAL SCHOOL, LAGOS.
HEALTH REPORT**

STUDENT NAME _____ GRADE _____ HR _____

In order to maintain current health records for all children, please complete this form and return it to the School Nurse as soon as possible. The information provided will offer considerable assistance to the school in dealing with acute/emergency and chronic health problems should they arise during school hours.

CIRCLE ONE ANSWER

1. Has your child been in good health in the past year? YES NO

If no, please explain _____

2. Has your child had any of the following in the **past three years?**

- | | | |
|--|-----|----|
| a) Illness lasting more than three (3) days | YES | NO |
| b) Seizures, Convulsions | YES | NO |
| c) Severe injuries or accidents | YES | NO |
| d) Fractures or broken bones | YES | NO |
| e) Hospitalizations | YES | NO |
| f) Operations | YES | NO |
| g) Problems with eyes or seeing | YES | NO |
| h) Excessive bleeding when cut (Nose bleeding) | YES | NO |
| i) Problems with ears or hearing | YES | NO |
| j) Allergies | YES | NO |
| k) Physical restrictions due to a heart murmur
or heart problem | YES | NO |
| l) Asthma or breathing problems
(P.E activities exclusion) | YES | NO |
| p) Kidney or Bladder infection | YES | NO |
| q) Diabetes | YES | NO |

If yes to any of the above please explain _____

3. a) Is your child currently under the care of a physician or clinic? YES NO

b) Is your child currently taking any medication? YES NO
or receiving any treatments?

If yes to either of the above please explain _____

Describe unusual factors regarding birth or health immediately after birth

4. Does your child wear glasses, contact lenses or a hearing aid? **If yes please circle those, which apply.**

Glasses Contacts Hearing Aids

5. Has your child seen a dentist in the past year? YES NO

**MEDICAL HISTORY
IMMUNIZATIONS AND TEST**

VACCINE	Enter Month, Day, and Year each Immunization was given			BOOSTER & DATES	
	DOSES				
Diphtheria and Tetanus (circle):DTaP, DTP, DT, TD	1. / /	2. / /	3. / /	4. / /	5. / /
Polio (circle):OPV, IPV	1. / /	2. / /	3. / /	4. / /	5. / /
Measles, Mumps, Rubella	1. / /	2. / /			
Hepatitis B	1. / /	2. / /	3. / /		
HIB	1. / /	2. / /	3. / /		
Varicella	1. / /	2. / /	Varicella Disease of Lab evidence Date_____		
Other _____					

Emergency Doctor's Name: _____

Contact Information: _____

6. Has any member of the family developed any serious health problems within past year? YES NO
If yes please explain _____

7. Do you think your child is fit to participate in all school activities? and phys. ed.? YES NO
If no please explain _____

**EMERGENCY INFORMATION
ACTION IN CASE OF EMERGENCY**

In the event my child is injured or becomes seriously ill, and no responsible person from the home or family doctor can be reached. I hereby delegate the principal or his delegated agent to do what ever he feels is in the best interest of my child.

If the paragraph above is not acceptable, parents or guardians will describe an alternative action to be followed when the school cannot reach either parent or