



## AISB 2022 - 2023

### STUDENT MEDICAL INFORMATION

Please note a copy of your child's vaccination record must be Submitted with this form

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Female  Male   
Month Day Year

Blood Type \_\_\_\_\_ Medication(s) taken regularly \_\_\_\_\_

## HEALTH HISTORY

	Yes	No		Yes	No
Abdominal complaints	<input type="checkbox"/>	<input type="checkbox"/>	Injuries, Burns	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Bronchial Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
ENT (Ear/Nose/Throat)	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Genital Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Skin &/or Scalp Infections	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Disorders	<input type="checkbox"/>	<input type="checkbox"/>

Please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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1. Please provide any other health information of which we should be aware \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Please indicate any adverse reactions to vaccines \_\_\_\_\_

3. Has your son/daughter ever undergone surgery? Yes  No

If yes, please explain \_\_\_\_\_

4. Has your son/daughter ever been hospitalized? Yes  No

If yes, please explain \_\_\_\_\_

5. Does your son/daughter wear glasses? Yes  No  Contact lenses? Yes  No

6. Is your son/daughter allergic to any prescribed medications (i.e. penicillin)? Yes  No

7. Does your son/daughter have any physical disability, which would prohibit him/her from participating in our physical education program or on our sports teams? Yes  No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### I hereby grant AISB permission to

**administer non-prescriptive medications to my son/daughter.**

**admit my son/daughter to a hospital/clinic in case of an emergency.**

Parent Name Printed \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

NOTE: A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS MUST ACCOMPANY THIS FORM.