Student Medical Form
Chiang Rai International Christian School

PERSONAL DATA **Date:** ☐

Last Name: ☐ First name: ☐ Birth Date: ☐

Sex: ☐ Male ☐ Female Race: ☐ Blood Type: ☐

HEALTH CONDITIONS – Please check any that this child has had:

- ☐ Abnormal spinal curvature (scoliosis, etc.)
- ☐ Allergies or hay fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or wheezing
- ☐ Bedwetting at night
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer, type
- ☐ Chicken pox
- ☐ Chronic diarrhea or constipation
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Eating Disorder (Anorexia/Bullemia)
- ☐ Eczema
- ☐ Emotional disturbance
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent skin infections
- ☐ Frequent sore throat infections
- ☐ Heart disease, type
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney disease, type
- ☐ Measles (“old fashioned” or “ten day”)
- ☐ Meningitis or encephalitis
- ☐ Multiple ear infections (3 or more)
- ☐ Mumps
- ☐ Near-drowning or near-suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Poor hearing
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Seizures (minor or major) or epilepsy
- ☐ Speech Difficulties
- ☐ Stool soiling
- ☐ Substance abuse (alcohol, drugs)
- ☐ Suicide attempt
- ☐ Toothaches or dental infections
- ☐ Urinary tract infections
- ☐ Wetting during day

If you CHECKED any of the above please give a brief description

☐

ALLERGIES – Please list and describe allergies or adverse reactions to:

Medicines/drugs ☐

Foods/plants/animals/other ☐

Recommended treatment if allergies are severe ☐

INJURIES AND ILLNESSES – Please list any severe injuries or illnesses:

Injuries/Illness	Age of Child	If hospitalized (check)
		☐
		☐
		☐

ADDITIONAL INFORMATION

What medications are given daily? ☐

What medications are given frequently, but not daily? ☐

This child is usually: ☐ very active ☐ normally active ☐ rather inactive

Recent physical changes regarding:

- ☐ weight lose
- ☐ chronic fatigue
- ☐ loss of appetite
- ☐ chronic cough

Do you have any concerns about your child's ability to relate well with others? ☐ Yes ☐ No
If yes, please explain.

Do you have any concerns about your child's ability to learn? ☐ Yes ☐ No
If yes, please explain.

CERTIFICATION OF IMMUNIZATION

Immunizations (required) **Vaccine Doses Administered**

Please enter date of vaccination: Mon/Day/Year, Example: 12/31/79

DTP: Diphtheria Tetanus Pertussis	(2 months old)	(4 months old)	(6 months old)	(18 months old)	(4-6 years old)
dT: Diphtheria Tetanus	(> 6 years old)	(every 10 year)	(every 10 year)		
(Please check) **OPV** ☐ Poliomyelitis **IPV** ☐ needs 4 doses	(2 months old)	(4 months old)	(6 months old)	(18 months old)	(4-6 years old)
MMR: Measles, Mumps, Rubella	(9-12 months old)	(4 -6 y-o)			
HBV: Hepatitis B Vaccine	(at birth)	(2 months old)	(6 months old)		
BCG vaccine: prevent form TB (tuberculosis) ***(optional)***	(at birth)				
Other vaccinations					

Note; CRICS policy about Immunizations from parent/student handbook :

Immunizations; Parents Upon notice from CRICS, the parents must see the child receives any immunizations still needed for the child's protection. If the immunizations are not started within 14 days from CRICS notice, the child will not be allowed to return to school, starting the 15th day, until the immunizations are begun.

Do you have other comments or concerns about his child's health, development, behavior, family or home life that you would like the school to be aware of?

EMERGENCY CONTACT IF A PARENT OR GUARDIAN CANNOT BE REACHED:

***Mandatory Information: Names and numbers of at least **2** individuals, other than the primary care giver who can make decisions, and care for your child if CRICS is unable to reach the student's parents or guardian.*

1) Name: Home phone: Cell phone:
2) Name: Home phone: Cell phone:

MEDICAL SERVICE

Name of Doctor : Telephone:

Address:

***A medication administration form, available in the office, must be completed by a parent/legal guardian for any medications that willbe administered at school (i.e. antibiotics, daily medications, etc.)**I herby authorize the CRICS health office to treat any minor discomforts and give over the counter medications as needed (only Tylenol/Paracetemol, Ibuprofen or antacids at the recommended dosage will be given orally). I give permission for my child to receive emergency medical treatment at the discretion of the CRICS health office and agree to assume responsibility for payment of such services.**

Signature of Parents/Guardians

_______________________________ Date:

_______________________________ Date: