



## Gyeonggi Suwon International School Entrance Health Form

School APID#: \_\_\_\_\_

English Name : Student's Name (Last , First Name)	Date of Birth (yyyy/mm/dd)	Sex: Male ( ) Female ( )	Entering Grade: PreK K 1 2 3 4 5 6 7 8 9 10 11 12
Korea Name :			
Father's or Legal Guardian's Name:		Office Phone	Cell Phone
Mother's or Legal Guardian's Name:		Office Phone	Cell Phone
Home Address:			Home Phone
Emergency Contact Name:	Relationship:	Home Phone	Cell Phone

### Permission for Giving Medication for Minor Complaints

I give permission for my child to be given medicine at the nurses discretion.

Tylenol (for minor aches, menstrual cramps, and headache)	(Yes)	(No)
Pepto Bismol (for nausea, diarrhea, stomach ache, and heartburn)	(Yes)	(No)
Benadryl (for allergies)	(Yes)	(No)

All boxes must be filled in

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

### Permission for Emergency Treatment

In the event that I cannot be reached in an emergency, I give permission for my child to receive medical treatment, including transport to the most accessible hospital, as deemed necessary by school authorities.

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

## Health History

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male ( ) Female ( )

Your accurate and thorough answers help us to better serve your child.

To the best of your knowledge, has your child had any problems with following? Please check yes or no.

Medical Condition	Yes	No	Comments if "Yes"	Medical problem	Yes	No	Comments if "Yes"
ADD or ADHD				Hearing Loss			
Anemia				Heart disease			
Anxiety/Panic Attacks				Hepatitis			
Asthma				Pneumonia			
Behavioral problems				Rheumatic Fever			
Bleeding Disorder				Scoliosis			
Chronic ear infection				Seizures			
Developmental problems				Substance Abuse			
Depression				Tuberculosis			
Diabetes				Vision Problems			
Excessive Fatigue				Other			

\* Describe any serious illness, surgery, injuries, or hospitalizations: \_\_\_\_\_  
 \_\_\_\_\_

\* Does any condition affect or limit your child's full participation in physical education classes, sports, or school trips? Yes ( ) No( )

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

\* Check here if you want to discuss confidential information with school nurse or other school authority: Yes( ) No( )

## Immunization History

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male ( ) Female ( )

Immunization	Record complete dates (yyyy/mm/dd) of vaccine dose given				
DPT	①	②	③	④	⑤
Td Booster	①				
Poliovirus	①	②	③	④	
MMR	①	②			
Hepatitis B	①	②	③		
Varicella	①	Date of Varicella Disease:			
Other					
TB Screening (to be completed by a school nurse)					

List all prescription and over-the-counter medications your child takes regularly:

Name of medication	Reason	Dose/How often

Does your child have any allergies? None \_\_\_ Yes \_\_\_ (If yes please describe)

Specify Allergies (Medication, food, environment, or other)	Describe Reaction	Treatment

## Medical Exam (This page to be done by physician)

Student's Name (last, first, M.): \_\_\_\_\_ Entering Grade \_\_\_\_\_ Date of Birth (yyyy/mm/dd): \_\_\_\_\_

Dear Doctors: For the items that you don't think necessary for this child. Please be strict on immunization.

If you cannot find any records of immunization, please administer appropriate immunization. TB skin test should be administered every other year.

Age \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Hgt. \_\_\_\_\_ Wgt. \_\_\_\_\_ Nutritional Status: \_\_\_\_\_

Eyes/Ears/Nose/Throat		Neck/Spine	
Heart/Lungs		Extremities/ROM	
Abdominals		Skin	

Please administer the following tests as well as any others needed.

URINALYSIS (results) \_\_\_\_\_ HEMOGLOBIN (results) \_\_\_\_\_

GSIS require evidence of immunization for the following:

DPT #1 _____ #2 _____ #3 _____ #4 _____ #5 _____	OPV (polio) #1 _____ #2 _____ #3 _____ #4 _____	MMR #1 _____ #2 _____	DT _____
TB skin test (every two years) date _____		Result _____	

I have seen evidence that these have been administered. Yes \_\_\_\_\_ No \_\_\_\_\_

Please be strict on immunization. Students who have lost records must have one OPV, DT, MMR booster along with the Tuberculin skin test.

Please administer appropriate immunization to complete records.

Comments \_\_\_\_\_

I certify that this student has been examined by me. This examination shows that this student is physically able to participate in physical education activities, including inter-scholastic sports, unless otherwise specified above.

Physician's Signature \_\_\_\_\_ Clinic/Hospital \_\_\_\_\_