

Gyeonggi Suwon International School Entrance Health Form

School APID# _____

Student's Name; Last Name _____ First Name _____ Korean Name _____	Date of Birth _____ Month Day Year	Sex Male _____ Female _____	Entering Grade PK K 1 2 3 4 5 6 7 8 9 10 11 12
Father's or Legal Guardian's Name:		Work Phone:	Cell Phone:
Mother's or Legal Guardian's Name:		Work Phone:	Cell Phone:
Home Address:			Home Phone:
Emergency Contact Name:	Relationship:	Home Phone:	Cell Phone:

Permission for giving medication for minor complaints

Acetaminophen (Tylenol) (for minor aches, menstrual cramps or headache etc...)	Yes	No
Pepto Bismol (for nausea, diarrhea, stomachache or heartburn etc...)	Yes	No
Benadryl (for allergy)	Yes	No

I give permission for my child to be given medication at the nurse's discretion.

Parent's 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's Signature _____

Date _____

Health History

(To be completed and signed by parents/guardian and verified by healthcare provider)

Student's name _____ Date of Birth _____ Sex; male _____ female _____ Grade _____

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis)				
Diagnosis of asthma?	Yes	No	Describe in detail	Loss of function of one of paired organs?(eye/ear/kidney/testicle)	Yes	No	Describe in detail
Child wakes during the night coughing?	Yes	No		Hospitalizations?	Yes	No	
Birth defects?	Yes	No		When? What for?			
Developmental delay?	Yes	No		Surgery? (List all)	Yes	No	
				When? What for?			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes	No	
Head Injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes	No	
Seizures? What are they like?	Yes	No		TB disease (past/present)?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problem? Other concerns?	Yes	No	Glasses____ Contacts____ Crossed eye____ Drooping lids____ Squinting____ Difficulty reading____	Dental Device	Yes	No	Braces____ Bridge____ Plate____ Other_____
Ear/Hearing problem?	Yes	No		Other concerns?	Yes	No	
Bone/Joint problem/Injury/Scoliosis?	Yes	No					

Information may be shared with appropriate personnel for health and educational purposes.

Parents/Guardian: Signature _____ Date _____

Physical Examination

(to be completed by Physical Doctor)

Student's name _____ Date of Birth _____ Sex; male _____ female _____ Grade _____

HIGHT _____ **WEIGHT** _____ **BP** _____

TB SCREENING;		TB SKIN TEST _____		or CHEST X-RAY _____	
LAB TESTS* recommended only by physician	Date	Results		Date	Results
Hemoglobin or Hematocrit			other		
Urinalysis					
SYSTEM REVIEW	normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes			Genito-Urinary		
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal examination		
Cardiovascular			Nutritional status		
Respiratory			Mental Health		
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, prostatic device, dental bridge, false teeth, athletic support/cup					
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel. Check title ; nurse___ teacher___ counselor___ Principal___					
EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes _____ No _____ If yes, please describe.					
On the basis of the examination on this day, I approve this child's participation in (If no or modified attach explanation.) PHYSICAL EDUCATION Yes ___ No ___ Modified ___ INTERSCHOLASTIC SPORTS(for one year) Yes ___ No ___ Limited ___					
Physician Printed name:		Signature:		Date:	
Address:			Phone:		

