GSIS ENTRANCE HEALTH FORM

GYEONGGI SUWON
INTERNATIONAL SCHOOL

GSIS requires that your child is immunized and receives a comprehensive physical examination before entering GSIS.
The parent completes Part I of the form. The physician completes Part II of the form.
This form must be completed no longer than 6 months before your child's entry into GSIS.

If there are any questions, please contact the Nurse office (031-695-2829, 8am - 3pm).

Part I -1. Student and Family Information

Student's Name	**Date of Birth**	**Sex**	**Entering Grade**
Last Name___________________ First Name___________________ Korean Name___________________	____________________ Month Day Year	Male_____ Female______	PK K 1 2 3 4 5 6 7 8 9 10 11 12
Father's or Legal Guardian's Name:		Cell Phone:	Email:
Mother's or Legal Guardian's Name:		Cell Phone:	Email:
Home Address:			Home Phone:
Emergency Contact Name:	Relationship:	Home Phone:	Cell Phone:

Part I - 2. Medication Permission

Please check the following list of common medications, which the school nurse may administer to your child as needed at school.

Medication	Permission	Medication	Permission
Acetaminophen(Tylenol) - pain and fever relief	□ Yes / □ No	Cough Syrup - for cough	□ Yes / □ No
Ibuprofen(Advil) - pain relief and anti-inflammatory	□ Yes / □ No	Minol Troches(Lozenge) - sore throat relief	□ Yes / □ No
Tylenol cold - for general cold symptoms	□ Yes / □ No	Benadryl - for allergic reactions	□ Yes / □ No
Sudafed(Non-drowsy) - for nasal/sinus congestion	□ Yes / □ No	Pepto-bismol - for stomach indigestion, nausea, and diarrhea	□ Yes / □ No

Part I - 3. Medical History

Allergies (food, medicine, insect, seasonal)	□ Yes / □ No	Frequent Headaches	□ Yes / □ No
Asthma	□ Yes / □ No	Hearing Problems	□ Yes / □ No
Diabetes	□ Yes / □ No	Heart Disorder	□ Yes / □ No
Epilepsy/Seizure Disorder	□ Yes / □ No	Hepatitis A/B/C	□ Yes / □ No
ADD/ADHD	□ Yes / □ No	Scoliosis	□ Yes / □ No
Anxiety Disorder	□ Yes / □ No	Skin Problems	□ Yes / □ No
Chicken Pox	□ Yes / □ No	Speech Difficulty	□ Yes / □ No
Gastrointestinal Disorder	□ Yes / □ No	Vision Problems	□ Yes / □ No
Frequent Nosebleeds	□ Yes / □ No	Other health problem	□ Yes / □ No

- If you have answered **YES** to any of the above or your child has any **additional medical issues,** please explain in detail:

- List any **medication** the student takes on a regular basis:

- Has your child ever had **surgery / hospitalization** in the past? □ Yes / □ No
  If **YES**, please give date(s) and details:

- If you have answered **YES** to **Allergies,** please describe

Specify Allergies (food, medicine, insect, seasonal or other)	**Reaction**	**Treatment**

Part I - 4. Emergency Care Permission

- Permission is hereby given for emergency measures to be taken in case of accident or sudden illness with the understanding that I will be notified as soon as possible.
- I certify that all information given on this form is complete and correct.
- I acknowledge that it is my responsibility to inform the Nurse Office of any changes in my child's health, physical condition, or medical need

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

Parents/Guardian: Signature_______________________________________ Date____

Part II - 1. Immunization Record

* GSIS follows the Korea CDC immunization schedule. Please help us ensure the student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio, & MMR at age 4-6 and DT/Td/Tdap at age 11-12.

* **Please PRINT the exact dates (mm/dd/yr) of vaccinations received.**

Type of Vaccine		**1st Dose mm/dd/yr**	**2nd Dose mm/dd/yr**	**3rd Dose mm/dd/yr**	**4th Dose mm/dd/yr**	**5th Dose mm/dd/yr**
DPT/DTaP: Diphtheria, Tetanus, & Pertussis		2 months	4 months	6 months	15-18 months	4-6 years
		/ /	/ /	/ /	/ /	/ /
DT/Td/Tdap: Tetanus & Diphtheria		11-12 year				
		/ /				
Polio		2 month	4 months	6-18 months	4-6 years	
		/ /	/ /	/ /	/ /	
MMR: Measles, Mumps, & Rubella		12-15 months	4-6 years			
		/ /	/ /			
OR Separated MMR Vaccines	**Measles**	/ /	/ /			
	Mumps	/ /	/ /			
	Rubella	/ /	/ /			
Hepatitis B		#1	#2	#3		
		/ /	/ /	/ /		
Varicella (Chicken pox) Or Disease History		12-15 months	4-6 years	**Disease History**		
TB Screening (School Nurse ONLY)						

Hospital Name / Phone Number / Physician Signature (or Stamp)	**Date of Verification (mm/dd/yr)**

Part II – 2. Comprehensive physical Examination Report

* This page needs to be filled out by a **PHYSICIAN**.

Student's Name: Last______________ **First**_________________________ **Middle** __________ **Date of Birth (mm/dd/yr):** _____/______/_______ **Grade:** _____________

Height: _______cm Weight: _____kg Blood Pressure ______/______ (ONLY for students age 11 and older) Pulse___________

Vision: R ________ L _________ Both __________________ Corrective Lens: ☐ Yes / ☐ No

Please administer the following tests.	Date (mm/dd/yr)	Result
Tuberculosis Skin Test OR Chest X-ray (NOTE: If TB skin test result is positive, chest X-ray is required regardless of previous BCG vaccination)		TB skin test: Chest X-ray:
Hemoglobin (Secondary students only)		
Urinalysis		

	Normal	**Abnormal**		**Normal**	**Abnormal**
Ears/Hearing			Musculoskeletal		
Nose			Spine		
Mouth			Skin		
Throat			Neurological		
Neck			Nutritional		
Heart			Emotional/Psychological		
Lungs			Behavior		
Abdomen			Speech		

Physician's Comments:

» **This student is physically able to participate in all physical education and sports activities:** ☐ **Yes** / ☐ **No**

If NO, please explain:

____

Hospital Name / Phone Number / Physician Signature (or Stamp)	**Date of Examination (mm/dd/yr)**