IMPORTANT: Parents must fill out the information requested below (in print) and complete pages 2-3 of this form. Page 4 must be completed by a licensed physician.

Dominican International School Kaohsiung
107 Chung Hua 1st Rd., Kaohsiung 80455 Taiwan, R.O.C.
Admissions Office: **552-3989 ext. 21**
Scan and email to: **atsou@disk.kh.edu.tw**

H E A L T H R E C O R D F O R M

Please paste Passport size photo here

Name of Pupil / Student (List all names as recorded in foreign passport)

Last Name *First Name* *English Name*

Applying for **Gr.** Gender: ☐ Male ☐ Female Date of Birth ____ ____ ____ ____ Year ____ ____ Month ____ ____ Day

Citizenship _____ Religion _____

Student resides with ☐ Both Parents ☐ Father ☐ Mother ☐ Guardian

	Father / Guardian	**Mother / Guardian**
Name		
Home Address		
Home Phone No.		
Mobile Phone No.		
Office Phone No.		
Company Name		
Email Address		
Languages Spoken		

FOR EMERGENCY (If Parents Cannot Be Reached)					
Primary Contact		Phone no.		Mobile No.	
Secondary Contact		Phone no.		Mobile No.	
Local Doctor		Phone No.		Mobile No.	

NOTE: Please notify the Admissions Office of any changes in phone numbers or contact persons.

MEDICAL INFORMATION and HEALTH HISTORY

1. *Does the applicant suffer from any allergies?* ☐ No ☐ Yes

   Please describe the allergy? (food, drugs, etc.) _____

   *Reaction:*_____

   If yes, is there history of severe allergic or anaphylactic reaction? ☐ No ☐ Yes

   Does the applicant carry an AAI (adrenaline auto-injector, e.g. Epipen?) ☐ No ☐ Yes

2. *Does the applicant have any history of serious respiratory reaction to a food, bee sting or a drug?* _____

3. *Is the applicant asthmatic?* ☐ No ☐ Yes *Does the applicant carry an asthma inhaler?* ☐ No ☐ Yes

4. *Is the applicant on regular medication:* ☐ No ☐ Yes

   If yes, name of medication/s and frequency of use: _____

   (a letter from a Medical Doctor must be kept on file in the Clinic and the medication/s kept in the Clinic to be dispensed by the School doctor or nurse.)

5. *Does the applicant have any present illness:* ☐ No ☐ Yes

   If yes, describe: _____

6. *Does the applicant wear eye glasses or contact lenses:* ☐ No ☐ Yes

   If yes, describe eye or vision problems: _____

7. *Does the applicant have hearing problem(s):* ☐ No ☐ Yes

   *If yes, describe:*_____

HEALTH HISTORY

Please indicate if your child had any of the following conditions. If the answer is yes to any, please give details below.

	No	Yes	Age
Diabetes			
Meningitis			
Tuberculosis			
Fainting Spells			
ADD / ADHD			

	No	Yes	Age
Heart Disorder			
Urinary Disorder			
Epilepsy			
Scoliosis			
Skin Disease			

Describe :_____

_____

_____

_____

_____

_____

_____

_____

Hospitalization, Serious Injuries/Illness? (Please give details.) _____

_____

_____

FOR GIRLS:

☐ Irregular Menstrual Periods ☐ Amenorrhea (the absence of periods)

☐ Dysmenorrhea (painful periods) ☐ Menorrhagia (extremely heavy periods)

IMMUNIZATION RECORD

To be filled out by parents. Please attach or complete schedule below, include dates for childhood vaccinations.

TYPE	DATE/S
DPT / DT	
Polio	
Measles	
Mumps	
Rubella	
Tetanus booster	
Hepatitis A	
Hepatitis B	
Varicella (chicken pox)	

AUTHORIZATION

I give consent for my child to receive the following:

1. Minor first aid (at the clinic) ☐ Yes ☐ No
2. Emergency care (at the clinic) ☐ Yes ☐ No
3. Emergency care (at hospital Emergency Room) ☐ Yes ☐ No
4. Oral non-prescription medication ☐ Yes ☐ No

I hereby authorize the DIS designated Dentist to give the following dental treatment to my child, as the need arises:

1. Emergency dental examination ☐ Yes ☐ No
2. Emergency dental treatment ☐ Yes ☐ No

I give consent for my child to participate in the following:

☐ 1. Regular program of strenuous activities and sports

☐ 2. Limited activities (Special restrictions, duration and reasons):

_____

☐ 3. No physical education or sports activities (special restrictions, duration and reasons):

_____

I hereby give permission for emergency measures to be initiated 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 DIS Clinic of any changes in my child's health, physical condition or medical needs.

_____ _____ _____

Father / Guardian Printed Name and Signature | Mother / Guardian Printed Name and Signature | Date

PHYSICAL EXAMINATION - To be completed by a Licensed Physician.
This form is mandatory for school admission.

Height (cm) _____ Weight (kg) _____ Blood Pressure _____ Vision: R _____ L _____ Blood Type _____

Please review the following areas:	*Normal*	*Findings*	*DESCRIPTION (attach additional sheets if necessary)*
1. Head, Eyes, Ears, Nose, Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Genitourinary			
7. Musculoskeletal			
8. Metabolic / Endocrine			
9. Neuropsychiatric			
10. Skin			
11. Mammary			

Describe Findings:_____

_____

_____

Comments (Please give details.) _____

_____

_____

_____

ASSESSMENT

I hereby certify that each examination listed above was performed by myself / under my direct supervision with the following conclusion(s)

_____	_____	_____	_____
Physician's Printed Name	Signature and Title	License Number	Date

_____	_____
Address	Contact Numbers