Ibrahim International School

STUDENT HEALTH FORM

PART 1 : To be filled by Parents or Guardians Only

STUDENT NAME

FIRST	**MIDDLE**	**LAST**

DATE OF BIRTH

DATE	**MONTH**	**YEAR**

GENDER **M** ☐ **F** ☐

COMPLETE ADDRESS DETAILS:

_____

_____

PARENTS DETAILS:

NAME OF MOTHER	**MOBILE NUMBER**	**WORKPLACE NUMBER**

NAME OF FATHER	**MOBILE NUMBER**	**WORKPLACE NUMBER**

Name of the Person, other than Parents who could be contacted in emergency

NAME	**RELATION**	**CONTACT NUMBER**

NAME	**RELATION**	**CONTACT NUMBER**

In case of Emergency, Name & Telephone number of your Clinic /Local Physician whom you would like us to contact

NAME	**PHYSICIAN NUMBER**	**CONTACT NUMBER**

In case of emergency may we take your Child to Bahria International Hospital Rawalpindi?

YES ☐

NO ☐

Dose the Child have any?

☐ **Allergies**

☐ **Unusual Health Problems or Special Needs (e.g. Diabetes, Asthma, ADHD)**

☐ **Dietary Restrictions**

☐ **Regular Medication Given**

NAME	**DOSE**	**Time Give**

If you've checked any of the above please explain

_____

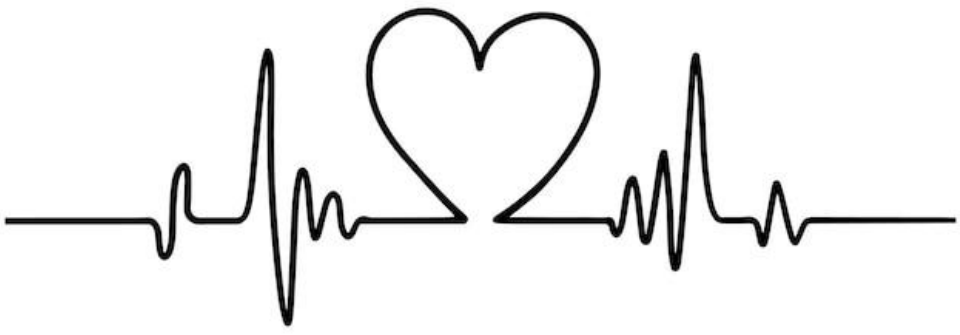
_____

If you wish to give permission for the nurse to give the basic medication to your child at School, Please Check

☐ **Paracetamol (Tylonel)** ☐ **Antacid** ☐ **Decongestant**

☐ **Ibeprefun** ☐ **Throat lozenges**

☐ **Any other medication that Doctor may decide**



Ibrahim International School

STUDENT HEALTH FORM

Part II: To be filled by a Child Specialist or Child's Regular Physician

STUDENT NAME: _____ **DATE OF BIRTH:** _____

GENDER **M** ☐ **F** ☐

Vision Screening	**Right Eye 20/ _____**	**Left Eye 20/ _____**	**Left Eye 20/ _____**
Hearing Screening	**Right Ear_____**	**Left Ear_____**	**Equipment Used_____**

General Physical Examination:
General appearance:
Nutritional Status:
Posture / Motor Behaviour:
Ear Nose Throat:
Heart:
Lungs:
Abdomen:
Genitalia (Tanner Stage):
Bones, Joints, Muscles:
Neurological:
Skin:
Other:
Estimated Developmental Level:
Summary of abnormal findings, if any:

Weight
_____

BP
_____

Height
_____

Blood HB
_____

Blood Group
_____

URINE
Albumin
_____
_____

Medical Diagnoses: _____

Assessment: _____

Recommendations and referrals made, if any:

_____

_____

Physician Name: _____ **Physician Number:** _____

Physician Address: _____

Physician Signature: _____ **Date:** _____

Ibrahim International School

STUDENT HEALTH FORM

PART 111 : Immunization Record

STUDENT HEALTH FORM

IMMUNIZATION RECORD

DATES OF SERIES AND BOOSTERS	PRIMARY SERIES				BOOSTERS		
VACCINE TYPE	1ST DOSE M/D/Y	2ND DOSE M/D/Y	3RD DOSE M/D/Y	4TH DOSE M/D/Y	NO:1 M/D/Y	NO:2 M/D/Y	COUNTRY IN WHICH THE IMMUNIZATION WAS GIVEN
DPT							
DIPHTHERIA							
PERTUSSIS							
TETANUS							
POLIO (OPV/IPV)							
MMR							
MEASLES OR MMR							
MUMPS OR MMR							
RUBELLA OR MMR							
BCG/TYNE TEST							
HEPATITIS B				x			
HEPATITIS A				x			
RABIES							
TYPHOID							
MENINGITIS							

HEALTH SCREENING				
YEAR	HEIGHT	WEIGHT	VISION	HEARING

REQUIRED IMMUNIZATIONS OR REQUIRED NUMBER OF DOSES		
DOSE		OPV/IPV 4 Primary doses
BIRTH	OPV/IPV	Booster No 1 at 4-5 years
6WK	DPT&OPV/IPV	Booster No 2 at 11-12 years
10WK	DPT & OPV/IPV	DPT 3 Primary doses
14WK	DPT & OPV/IPV	Booster No 1 at 4-5 years
9 MO	MEASLES	Booster No. 2 at 11-12 years
15 MO	MMR	
4-6 YRS	DPT & OPV	MMR 1 Primary dose at 1 year
11-12 YRS	MMR	Booster at 11-12 years

Physician Name: _____ Physician Signature: _____

Physician Address: _____ Date: _____