

## STUDENT HEALTH CARD AND PHYSICAL EXAMINATION RECORD

This health card and the physical examination record must be on file at the campus office on the date the student enters school. The Admission Office must be notified of a change in guardianship should parents leave Indonesia without their children.



Photo  
3 x 4

Please complete the form below

### STUDENT AND FAMILY INFORMATION

Student ID Number : \_\_\_\_\_

#### Student

First Name : \_\_\_\_\_ Middle Name : \_\_\_\_\_ Family Name : \_\_\_\_\_  
 Sex : Male/Female  
 Date Of Birth : / / (date/month/year) Nationality : \_\_\_\_\_  
 Resides with :  Both parents  Mother  Father

#### Guardian/Other

Father/Guardian

Mother/Guardian

#### Home

#### Home

Address : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Address : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone : \_\_\_\_\_

Phone : \_\_\_\_\_

Hand phone : \_\_\_\_\_

Hand phone : \_\_\_\_\_

Language spoken : English/Other \_\_\_\_\_

Language spoken : English/Other \_\_\_\_\_

#### Employer

#### Employer

Name : \_\_\_\_\_

Name : \_\_\_\_\_

Address : \_\_\_\_\_  
 \_\_\_\_\_

Address : \_\_\_\_\_  
 \_\_\_\_\_

Phone : \_\_\_\_\_

Phone : \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Primary Contact : \_\_\_\_\_ Phone : \_\_\_\_\_ Hand phone : \_\_\_\_\_

Secondary Contact : \_\_\_\_\_ Phone : \_\_\_\_\_ Hand phone : \_\_\_\_\_

Local Doctor or Health Care Provider : \_\_\_\_\_ Phone : \_\_\_\_\_

Note: Please notify the office for any changes information above.

## IMMUNIZATION RECORDS

Please attach a copy of your child's immunization records or complete the schedule including dates.

Type	Date	Date	Date	Date	Date
DPT/DT Diphtherial/ Pertussis/Tetanus					
Polio					
Measles					
Mumps					
Rubella					
Typhoid Every three years					
Other Vaccinations					

Blood Group if known : \_\_\_\_\_

## MEDICAL INFORMATION

Allergies : No  Yes

Reaction : \_\_\_\_\_

Drug Allergies : No  Yes

Reaction : \_\_\_\_\_

Asthma : No  Yes

Does the student carry an asthma inhaler? No  Yes

Is the student on regular medication? No  Yes  Name of the medication and frequency \_\_\_\_\_

Does the student take any medications during school hours? No  Yes

Please list the name of medication and frequency : \_\_\_\_\_

Does the student wear glasses or contact lenses? No  Yes  Hearing aid? No  Yes

List any health condition that the school should be aware of : \_\_\_\_\_

Explain any limits on physical activity: None  \_\_\_\_\_

A student may not receive medication unless written permission is signed by a parent or guardian. Parents of primary school students will be contacted before any medication is given.

Permission is hereby given for the following medications to be administered to my child if judged appropriate by the person in charge: PANADOL - CELESTAMINE (ANTIHISTAMINE) - MYLANTA (ANTACID)

Signature of Parent: \_\_\_\_\_

Date : / /

Permission is hereby given for emergency measures to be initiated for my child in case of accident or sudden illness with the understanding that I will be notified. I certify that all information given on this form is complete and correct.

Signature of Parent: \_\_\_\_\_

Date : / /