YAS Center SL

2024/2025 Academic Year
School Entry Health Form

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

To Parent/Guardian: Please complete at the bottom of each page.

(Please Print)

Name of Child (Last, First, Middle)		**Birth Date**	**Sex**
Address		**School**	**Class**
City	**Home Telephone Number**	**Parent/Guardian (Last, First, Middle)**	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects etc.)? Please refer to **PART III**
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with the school?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

_____

Parent/Guardian signature:……

Date:……

PART II - IMMUNIZATION

To Parent/Guardian: The table below **must** be filled by a doctor or please attach clear scanned copies of original immunization files.

RECORD DATES OF IMMUNIZATIONS BELOW AND ATTATCH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD						
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTA VIRUS						
DTA/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						
Family Doctor:					SIGNATURE OF Family Doctor TITLE:	
		PHONE			DATE FORM SIGNED	

PART III - MEDICAL HEALTH CONDITIONS

To Parent/Guardian: This section is for child/children with health conditions that may require emergency action at school (***If your child/children has no health conditions, please proceed to PART IV)***

Please state if your child/children have any allergy or other Health Diagnosis:

Any Medication Prescribed? ***(Please attach prescription):***

Medication to be kept in school? ***(Please attach instructions for use):***

What your child should try to avoid ***(possible triggers)?:***

Symptoms to watch for:

Action to follow if symptoms are observed: ***(Note: Parent will always be notified if any symptoms are observed)***

All Emergency Contacts:

1. Name:_____ Number:_____
2. Name:_____ Number:_____
3. Name:_____ Number:_____

Parent/Guardian signature:……. *Date:*……

PART V - MEDICAL HEALTH CONDITIONS

In case of medical emergency, our first procedure is to move your child/children to the closest medical centre (Choithrams Hospital or Life Care Medical) while we contact parents. If you would like for us to use another option in case of an emergency, kindly indicate so below:

☐ **Please take my child to the closest medical centre (Choithram's Hospital or Life Care Medical) in case of any medical emergency.**

☐ **Please do not take my child to the closest medical centre (Choithram's Hospital or Life Care Medical) in case of any medical emergency.**

If I/we cannot be reached in case of a medical emergency, please use the following additional Local Emergency Contacts:

I. Name_____ Phone_____

II. Name_____ Phone_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I, II, III and IV of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services for the limited purpose of meeting my child's health and educational needs.

_____ _____

Signature of Parent/Guardian **Date**