

6. Tick any problems that your child has currently or previously had:

<input type="checkbox"/> Asthma (please state triggers)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hospitalized (operations)
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Seizures
<input type="checkbox"/> Behavioral and emotional	<input type="checkbox"/> Heart	<input type="checkbox"/> Eczema
<input type="checkbox"/> Other		

If any of the above, please give details including date(s):

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7. Tick any contagious diseases your child has had, and state the age it happened:

<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> German measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> Hand, foot and mouth		

8. In case that your child complains of minor pain or illness while at school, would you agree to allow the school nurse to apply preliminary medical treatment to your child?

Yes No

9. Is there anything else you would like us to know about your child's health and wellbeing?
Please use separate sheet if required.

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Student's Immunization Record

Student's Full Name (As it appears in the Passport) _____
 (Surname) (First name)
 Chinese Name _____

Vaccination	Date	Date	Date	Date	Date
Diphtheria Tetanus, Pertussis (DTaP)					
Rotavirus					
Hepatitis A					
Hepatitis B					
Japanese Encephalitis					
Meningitis A					
MMR (Measles, Mumps and Rubella)					
MR (Measles, Rubella)					
Haemophilus Influenzae Type B (HIB)					
Inactivated Polio Virus (IPV)					
TD (Tetanus and Diphtheria)					
Meningitis A and C					
Tuberculosis (BCG)					
Varicella					
Other					

PLEASE STATE WHAT COUNTRY'S VACCINATION SCHEDULE YOU ARE FOLLOWING:

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Parent's/Guardian's Name (print): _____

Parent's/Guardian's Signature: _____ Date: _____

Emergency Contact and Consent Form

Student's Full Name _____
 (As it appears in the Passport) Surname First name
 Chinese Name _____

EMERGENCY CONTACT INFORMATION:		
<u>1. Father's Name:</u>		
Mobile Phone:	Work/Additional Phone:	Home Phone:
<u>2. Mother's Name:</u>		
Mobile Phone:	Work/Additional Phone:	Home Phone:
<u>3. Guardian's Name:</u>		
Mobile Phone:	Work/Additional Phone:	Home Phone:
<u>3. Preferred Hospital Name:</u>		
Phone Number:		
Address:		

I/We understand that in the event of an emergency or a critical incident, every effort will be made to contact parents and that my/our child will be taken to a suitable hospital for treatment. I authorize members of the supervisory staff to approve such essential medical treatment for my child, as is deemed necessary, in an emergency or as a result of a critical incident, on the advice of a qualified medical practitioner. In such an event, I/we shall be liable for any costs incurred for the treatment.

Parent's/Guardian's Name (print): _____

Parent's/Guardian's Signature: _____ Date: _____