

Student Health Form



Deutsche Schule Nairobi
German School Nairobi

To be completed by Parent / Guardian

Student name (last / first / middle)

Date of birth

Grade

Home phone number

Email address

Mother's name

Mother's mobile number / work nr.

Father's name

Father's mobile number / work nr.

Your child may be released to the following individual for minor illnesses or injury, if custodial parents cannot be reached (Relative, Neighbour or Friend).

Name

Relationship

Phone number

Family doctor's name

Phone number

Hospital preferred: _____

Phone number

Parental permission is given for student to receive treatment and medication for minor illnesses or injuries at school. Please indicate 'Yes' or 'No' 'YES' 'NO' 'YES', with the following restrictions

Does your child have a health condition(s) which require **EMERGENCY ACTION** while he / she is in school (e.g. seizure, asthma, insect allergy, bleeding problems, diabetes, heart problem)? 'YES' _____ 'NO' _____

If 'YES', please describe _____

If your child has medication(s) for emergency action, please bring it to the School Nurse.



ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause concern and/or be important for school staff to know?
Please indicate 'YES' or 'NO' for each of the following.

Area of concern	No	Yes	Comments
Allergies (drugs,food,insects) Bee-sting reactions specify	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ear problem or deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eye or vision problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	
Limits of activity	<input type="checkbox"/>	<input type="checkbox"/>	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Problem with bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Problem with bowels	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Speech problem	<input type="checkbox"/>	<input type="checkbox"/>	
Others	<input type="checkbox"/>	<input type="checkbox"/>	



INFORMATION FOR SPORTS

Area of concern	No	Yes	Comments
Advised by physician to restrict activity	<input type="checkbox"/>	<input type="checkbox"/>	
Has been unconscious	<input type="checkbox"/>	<input type="checkbox"/>	
Has fainted	<input type="checkbox"/>	<input type="checkbox"/>	
Has had a convulsion(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Unusually short of breath under light exercise	<input type="checkbox"/>	<input type="checkbox"/>	
Has had sports injuries	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Weak or ill when exposed to high temperatures	<input type="checkbox"/>	<input type="checkbox"/>	
Has had surgery or fracture(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Others	<input type="checkbox"/>	<input type="checkbox"/>	

Is your child allowed to participate in all kinds of sports? 'YES' 'NO'

If 'NO', please describe _____

Comments and / or concerns regarding health and / or sports activities:

Is your child taking any medication regularly at home: 'YES' 'NO'

If 'YES': Name : _____

Dosage: _____

Reason: _____

Your child's **Blood Type**: _____ (if known)



IMMUNIZATION / INNOCULATION

Kindly indicate the last vaccination dates, so that in case of sickness we can give recommendations. It is **strongly recommended** by the school that your child has the following vaccinations. Please check for updates with a physician

Polio	_____	Measles	_____
Pertussis	P _____	Mumps	M _____
Diphtheria	D _____	Rubella	R _____
Tetanus	T _____	Meningococcal	_____
Hib (haemophilus influenza)	_____	BCG / TB	_____
Hepatitis A (after age of 10 years if no immunity)	_____	Anti-Rabies	_____
Hepatitis B	_____	Flu	_____
Yellow fever	_____		

MALARIA PREVENTION

Before every school trip outside Nairobi, parents / guardians should take advice from a physician concerning malaria prevention.

Please take note that some parts of the student’s file will be stored in a school computer for practical reasons.

Signature of Parent(s) / Guardian(s)

Date

OPTIONAL INFORMATION

If you like to discuss your child’s health with school personnel, please indicate title:

(School Nurse, Teacher, Counsellor, Principal or Special area Staff)

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Title _____

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BLOOD BANK – file (optional – to be used only for students)

Father's name _____ Blood Type _____

Mother's name _____ Blood Type _____

People who have had malaria within the last five years, known history of cancer or hepatitis cannot be blood donors.

Nurse's notes:
