

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

Pediatrician

Phone number

Parental permission is given for student to receive treatment and medication for minor illnesses or injuries at school:

☐

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, allergies, 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.

Deutsche Schule Nairobi
German School Nairobi
P.O. Box 978
00621 Nairobi, Kenya

Phone +254 (0) 733 445685
Email: +254 (0) 721 258417
nurse@germanschool.co.ke
mercy.chege@germanschool.co.ke

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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 (medications, food, animals, insect bites, pollen & grasses)	<input type="checkbox"/>	<input type="checkbox"/>	In case of allergies please describe reactions exactly!
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing problems / deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	
Tendency to faint	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	
Movement restrictions	<input type="checkbox"/>	<input type="checkbox"/>	
Rheuma / Juvenile Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis / HIV	<input type="checkbox"/>	<input type="checkbox"/>	
Premature	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with the bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with digestion	<input type="checkbox"/>	<input type="checkbox"/>	
Language problems	<input type="checkbox"/>	<input type="checkbox"/>	

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Please indicate 'Yes' or 'No' for each of the following.

Area of concern	No	Yes	Comments
Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	
ADHS / Autism	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Psychological problems	<input type="checkbox"/>	<input type="checkbox"/>	
Already had sports injuries / fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Has already had surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<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:

Please remember to renew the health form and inform the school nurse if there are any changes regarding the health of your child.

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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 (Poliomyelitis)	_____	Measles	_____
Whooping cough (pertussis) P	_____	Mumps M	_____
Diphtheria D	_____	Rubella R	_____
Tetanus T	_____	Meningococcus C	_____
Hib (haemophilus influenzae type B)	_____	Tuberculosis	_____
Hepatitis A (from 10 years, if no immunity)	_____	Rabies	_____
Hepatitis B	_____	COVID 19	_____
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

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