



St. John's International School

Student Health Record

(Please Print Clearly)

Personal Information			
Family Name		First name	
Date of Birth		Native Language	
Nationality			
Health Record			
Physical Checkup	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Most Recent Checkup	
Regular Medication	Yes <input type="checkbox"/> No <input type="checkbox"/>	Medication Name	
Chronic Illness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Illness	
Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Allergy	
Health Issues Affecting School Participation			
Does the student have any health issues, which might affect his/her performance in any school functions? Yes <input type="checkbox"/> No <input type="checkbox"/>	<u>Details:</u> 		
Allergy Details			Other Allergy Details: (Including allergies to medicine)
Name of Allergy			
Symptoms			
Medication	Yes <input type="checkbox"/> No <input type="checkbox"/>	Name:	
Seriousness	Mild <input type="checkbox"/> Serious <input type="checkbox"/> Requires Medical Attention <input type="checkbox"/>		
Other Health Concerns : Required an immunization records from a doctor			
<u>Explain in Detail:</u>			
Family Doctor			
		Name	Address
		Phone	
Can this student take Aspirin?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Can this student take Tylenol?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Can this student take Penicillin?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Signature of Applicant:		Signature of Parent/ Guardian: (If student is under 18 years of age)	
Date:			