Seoul International School
AUTHORIZATION FOR MEDICAL PROCEDURE

NAME OF STUDENT:_______________________________ **D.O.B.:**_______________________ **HOMEROOM/GRADE:** __________________

PART 1: PARENT/GUARDIAN AUTHORIZATION

- I request medication(s) be given during school hours as ordered by my child's physician. I also request the medication(s) be given to the field trips, as prescribed.
- I will notify the school of any change in the medication(s).
- I give permission for the medications to be given by the school personnel as delegated, trained, and supervised by the school nurse.
- I give permission for the school nurse to communicate, as needed, with school staff about my child's medical conditions(s) and the treatment prescribed.
- I give permission to S.I.S. to release appropriate medical information to the hospital in case of emergency.

PART 2: EMERGENCY CARE PERMISSION

- Permission is hereby given for emergency measures to be taken in case of accident or sudden illness with the understating that I will be notified as soon as possible.
- I acknowledge that it is my responsibility to inform Seoul International School Health Office of any changes in my child's health, physical condition, or medical needs

PARENT/GUARDIAN SIGNATURE:_________________________________ **Date:** _______________________

Seoul International School

STUDENT MEDICAL HISTORY & HEALTH FORM

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

STUDENT INFORMATION				
STUDENT'S NAME (Last, First):	DATE OF BIRTH (MM/DD/YYYY):	BLOOD TYPE:	SEX:	HOMEROOM (GRADE):
			Male ( ) Female ( )	
Father's Name (Last, First):	Cell #:	Mother's Name (Last, First):		Cell #:
Home Address:		Home Phone #:	Email Address:	

Emergency Contact (Other than parents):
Name:________________________________(Relation:) Contact number: ____________________

PAST OR PRESENT MEDICAL HISTORY							
Does the child/student have a past or present medical history of the following?							
ADD/ADHD	☐ Y ☐ N	Epilepsy/Seizure Disorder	☐ Y ☐ N	Hearing Problems	☐ Y ☐ N	Skin Problems	☐ Y ☐ N
Anxiety Disorder	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Heart Disorder	☐ Y ☐ N	Speech Difficulty	☐ Y ☐ N
Chicken Pox	☐ Y ☐ N	Frequent Nosebleeds	☐ Y ☐ N	Hepatitis A/B/C	☐ Y ☐ N	Vision Problems	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Gastrointestinal Disorder	☐ Y ☐ N	Scoliosis	☐ Y ☐ N	*Others:* ________________	☐ Y ☐ N

If you have checked on any of the above medical history, please explain in detail:

Does your child have allergies? ☐ **Y** ☐ **N**	
If YES, student is allergic to:	
Reactions the student may have:	
Treatments the student may need after exposure:	

Does your child have asthma? ☐ **Y** ☐ **N**	
If YES, does the student need an inhaler? ☐ Y ☐ N	☐ Y ☐ N
If the student needs an inhaler, please indicate if the inhaler will:	☐ remain with the student or ☐ be provided to the Health Office for emergency use.

If your child have other significant health conditions that may require emergency medical care at school, child care, field trip or sports activity, please explain in detail:

Seoul International School

STUDENT MEDICAL HISTORY & HEALTH FORM

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

STUDENT INFORMATION				
STUDENT'S NAME (Last, First):	DATE OF BIRTH (MM/DD/YYYY):	BLOOD TYPE:	SEX:	HOMEROOM (GRADE):
			Male ( ) Female	

CURRENT MEDICATION STATUS			
Medication Permission: Please check the following list of common medications which Health Office may administer to your child as needed at school			
Acetaminophen (Tylenol) - pain and fever relief	☐Y ☐N	Hexamedine/Tantum spray for sore throat	☐Y ☐N
Ibuprofen (Advil) - pain relief and anti-inflammatory	☐Y ☐N	Cegaton Troche - For sore throat, stomatitis	☐Y ☐N
Zyrtec (tablet) - for allergy (Nasal/Sinus Congestion)	☐Y ☐N	Festal — for stomach indigestion	☐Y ☐N
Please list any medication the student takes on a regular basis:			

IMMUNIZATION RECORD (DATES: MM/DD/YYYY)

DT aP	OPV / IPV	MMR	Chicken pox	TB Skin Test/Result	Tdap	HepB
1.	1.	1.	1.			1.
2.	2,	2.	2.			2.
3.	3.					3.
4.	4.					
5.						

IMMUNIZATION GUIDE AND REQUIREMENTS

	2 mo	4 mo	6 mo	15 mo	18 mo	4-6 yr	11-18 yr
DTap/Td	#1	#2	#3	#4		#5	Td/Tdap
OPV/IPV	#1	#2	#3			#4	
MMR				#1		#2	
Chicken pox				#1		#2	
T.B. Skin Test/Result	All students enrolled at Seoul International School are required to have PPD skin test OR chest X-ray every 2 years.						

Students who have lost records, must have one OPV booster, one DTaP *(if under 6 years of age) or Td (if under 18 years of age) booster, and one MMR booster along with annual TB Skin test. Complete record with appropriate immunizations.

It is parental responsibility to update medical records.

(Pease read page 1-3 and then sign) Signature / date

PHYSICIAN'S EXAMINATION
(MEDICAL EXAM MUST BE CURRENT – WITHIN 12 MONTHS OF ENTRY DATE)

______________________ Name (Last, First) ________ Grade ______________ Date of Birth (MM/DD/YY)

______________________ Sibling at SIS (name/grade)

Height__________cm Weight__________Kg Pulse __________

Vision R:___________L:____________ Both ___________________________

Blood Pressure ________/________ Corrective Lens □ YES / □ NO

(Blood Pressure only for students age 11 and older)

(O) Normal (X) Abnormal (Comment : Specify consultation requested)

Ears/Hearing		Musculoskeletal	
Nose		Spine	
Mouth		Skin	
Throat		Neurological	
Neck		Nutritional	
Heart		Emotional / Psychological	
Lungs		Behavior	
Abdomen		Speech	

Physician's Comments :

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Please list any medication the student takes on a regular basis.
Note : A separate medical form is required for all medication and treatment to be administered at school.

Name of Medication	Purpose	Dose/Times

This student is physically able to participate in all physical education and sports activities : □ YES / □ NO

If NO, Please explain : ____

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Required tests	Date (MM/DD/YY)	Result
TUBERCULIN SKIN TEST or Chest X-ray		
HEMOGLOBIN		
URINALYSIS		

(If TB skin test result is positive, chest X-ray is required regardless of previous BCG vaccination.)

SIS requires evidence of immunization for the following (MM/DD/YY):
I have seen evidence that these have been administered.
YES________________NO ________________

DT&P #1__________ #2__________ #3__________ #4__________ #5__________

OPV/IPV #1_________ #2_________ #3_________ #4_________

MMR #1__________ #2__________

HepB #1__________ #2__________ #3__________

Varicella #1_________ #2_________

Td/ Tdap 11-12 years #1__________

* Please print the exact date (MM/DD/YY) of vaccinations received.

NOTE TO THE PHYSICIAN : Please be strict on immunization. Students who have lost records must have the OPV booster, one DTap or Td (if between ages 11 and 18) booster, and one MMR booster along with the annual Tuberculin Skin Test. Please administer appropriate immunization for incomplete records.
Thank you.

Physician's Name	Signature
______________________	______________________
Hospital	Date
______________________	______________________