



# SHANGHAI REGO INTERNATIONAL SCHOOL

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## Student Medical History

Please complete this health form as your child's health is our primary concern. Should you require assistance completing this form, please contact the SRIS Nursing Office at (021) 5488 3431.

Student's Name (Last/First): \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth (dd/mm/yyyy): \_\_\_\_\_ Class: \_\_\_\_\_

### Person(s) to notify in an emergency:

Mother: \_\_\_\_\_ Home telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Father: \_\_\_\_\_ Office telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Other: \_\_\_\_\_ Home telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Preferred Doctor/Clinic: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

- **If you wish the school nurse to administer medication to your child, you should provide the nurse with the following WRITTEN information IN ENGLISH:  
Name of medication, dosage, time, and duration**
- **The school nurse may administer practical first aid in the event of an accident or injury. You will be contacted directly should the nurse consider your child needs minor medication on site.**
- I DO want my child to receive practical first aid
- I DO NOT want my child to receive practical first aid.

Is your child allergic to any medication? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

I hereby give SRIS permission to contact a doctor and/or transfer my child (please select) to Shanghai United Family Hospital (1111 Xian Xia Road) / the clinic specified above as my preferred clinic (please select) in case of emergency. I understand that SRIS will try to contact myself or the emergency contact person I have listed above as soon as possible.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

# Student Medical History

Does your child have anything of the following?

- |   |  |                                    |                                       |   |
|---|--|------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> frequent headaches     | <input type="checkbox"/> frequent stomachaches | <input type="checkbox"/> diabetes  | <input type="checkbox"/> dyslexia     | <input type="checkbox"/> dizziness      |
| <input type="checkbox"/> dermatological disease | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> allergies | <input type="checkbox"/> epilepsy     | <input type="checkbox"/> conjunctivitis |
| <input type="checkbox"/> menstrual problems     | <input type="checkbox"/> infectious disease    | <input type="checkbox"/> asthma    | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> others         |

Please attach additional information if you have ticked any of the above boxes: \_\_\_\_\_

In case of allergies, please list:

Drug: \_\_\_\_\_

Food: \_\_\_\_\_

Environmental: \_\_\_\_\_

Other: \_\_\_\_\_

Blood Type (please circle one): **A AB B O**                      RH Factor (please circle one): **POS NEG**

Does your child take medication on a regular basis? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Does your child have any physical limitations preventing him/her from taking part in PE classes? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Does your child wear contact lenses or glasses? \_\_\_\_\_

Dates of last examinations    medical: \_\_\_\_\_    vision: \_\_\_\_\_    dental: \_\_\_\_\_

Describe any serious illnesses, hospitalisations, operations or injuries: \_\_\_\_\_

**Please complete with details of your child's vaccinations    Name of vaccination/ Dates Received**  
**Date must be given for a complete application.**

Measles/Mumps/Rubella: \_\_\_\_\_

Diphtheria: \_\_\_\_\_

Pertussis: \_\_\_\_\_

Tetanus: \_\_\_\_\_

Poliomyelitis (Oral/Injection): \_\_\_\_\_

Hepatitis A (or gamma-globulin): \_\_\_\_\_

Hepatitis B: \_\_\_\_\_