INTERNATIONAL SAHAJA PUBLIC SCHOOL

ISPS Student Health Information Record

- This form is to be filled out in English, signed by the child's parent/guardian and returned to the school in original hardcopy at the time of enrolment.

- All sections must be completed and a current photo of your child provided for identification purposes.

- A new form must be completed at the beginning of each academic year.

- Please advise the medical staff if your child will require any ongoing dental work whilst at ISPS, and whether any prior arrangements have been made for this.

- The form must be accompanied by copies of (where applicable)
    - your child's current immunisation status record
    - dental records
    - vision tests
    - health care plans from specialists / other medical practitioners in your home country

ISPS Comprehensive Student Health Information Record 2014

Section A – Personal information

Please attach a current, passport sized photo of your child here

Students name: _____

Age: _____

Date of birth (dd/mm/yyyy): _____

Class: _____

Usual residential address of child:

_____

_____

_____

Country of residence of parents (if different to above):

_____

Family Contact Details – please state who to contact in case of emergency:

Name:_____

Relationship to student : Mother / Father / Guardian / Other _____

Contact number - Mobile:_____ (including country code)

Home:_____ (including country code)

Email address: _____

Preferred method of contact : Mobile / home phone / email / other _____

Alternative contact person (in case first person is not available)

Name:_____

Relationship to student : Mother / Father / Guardian / Other _____

Contact number - Mobile:_____ (including country code)

Home:_____ (including country code)

Email address: _____

Preferred method of contact : Mobile / home phone / email / other _____

Sharing of information and informed consent

Your child's health care information will be shared with staff on a "need to know" basis. Do you give permission for your child's health care information to be shared where necessary?
Yes □ No □

Does your child have one or more health conditions that ***will require support from staff***?
Yes □ (Details will be required in Section B of this form) No □

STUDENT'S NAME: CLASS:

Section B - Current health conditions

Does your child have any <u>allergies</u> to medication, foods or other substances?

No ☐ Yes ☐ - please list the allergy and type of reaction (e.g. rash, vomiting, anaphylaxis)

_____

_____

_____

Does your child suffer from any current health conditions – please tick if relevant

Severe allergy/anaphylaxis	☐
Minor and moderate allergies	☐
Asthma	☐
Eczema, psoriasis or other skin problems	☐
Other conditions (please specify) (Examples - intolerance to milk, wheat, gluten; suffers from congestion, may need steam inhalation)	☐

_____

_____

_____

_____

Has your child's medical practitioner provided a health care plan to assist the school in managing the above condition/s? (if applicable)

Yes ☐ Please inform the school nurse/doctor and provide a copy of the plan in English.

No ☐ Please meet with the school doctor during registration for further information.

Administration of medication

- Written consent must be provided for staff to administer any medication at the school.
- Parents will be informed immediately if there is a need for their child to be given any medication and consent sought, where possible
- In the event of emergency, students will be treated as per best practice guidelines.

Does your child require any regular medication? (e.g. asthma puffers)

No ☐ Yes ☐ - If yes, please list the details (including names, dosage & frequency)

_____

_____

_____

_____

Does your child require any medications to be given when required ? (e.g. for allergies)

No ☐ Yes ☐ - If yes, please list the details below (including when required)

_____

_____

_____

STUDENT'S NAME: CLASS:

Section C - Past medical history and background of student

Has your child had any major illnesses, hospitalisations and / or operations in the past ?

No ☐ Yes ☐ - If yes, please list the details e.g. illness /procedure, year, country

_____
_____
_____
_____
_____

Has your child needed to see a specialist for any medical condition in the past?

No ☐ Yes ☐ - If yes, please list the details below e.g. reason, year, country

_____
_____
_____
_____
_____

Has your child been immunised against any of the following ? Please tick where relevant.

- **If you are not sure how to answer, then please discuss with the school medical staff.**
- **Please include a copy of your child's immunisations record for our records.**
- **NB: Not all of these vaccines are required, but are included in some vaccine programs.**

Hepatitis B	☐	Polio	☐	Meningococcal C	☐
Haemophilus (Hib)	☐	Chicken pox	☐	Tuberculosis (BCG)	☐
Diptheria	☐	Rotavirus	☐	Hepatitis A	☐
Tetanus	☐	Pneumococcal	☐	Typhoid	☐
Pertussis (whooping cough)	☐	Measles, mumps, rubella	☐	Other: _____	☐

Is there a family history of any medical conditions (e.g. asthma, allergies, diabetes) ?

No ☐ Yes ☐ - If yes, please list the details below

_____
_____
_____

Are there any other details with regards to your child's health which we should be aware of?

_____
_____
_____
_____
_____
_____

Section D - Dental information

Does your child have any significant dental history which the school should be aware of, such as previous fillings, extractions, dental work?

No ☐ Yes ☐ - If yes, please list the details

_____
_____
_____

Is your child currently undergoing any dental or orthodontic treatment which needs to be continued whilst at ISPS?

No ☐ Yes ☐ - If yes, please provide details from your dental practitioner.

_____
_____
_____
_____

Section E - Eye history

Does your child wear glasses?

No ☐ Yes ☐ - If yes, please provide details from your most recent assessment.

_____
_____

Vibrational treatments

All children who are assessed by the school nurse or doctor, will be treated along Sahaj guidelines using vibrational treatments, with the use of allopathic and other medications only when necessary. Please indicate if there are any particular vibrational treatments which you have found to be effective for your child (or would like to be used for your child).

_____
_____
_____
_____

Parent / guardian consent to treatment

- I understand that all reasonable efforts will be made to contact the person(s) nominated on this form, prior to the commencement of any course of medication.
- In the event that I cannot be contacted, I accept that my child will be treated as per accepted best practice guidelines, which may include the use of allopathic medications.
- In the case of an emergency, I authorise the school doctor, nurse or person appointed by ISPS, to act as my child's legal guardian and to make medical decisions as required.

Parent / guardian's signature: _____

Parent / guardian's name: _____ Date: _____