KOREA FOREIGN SCHOOL

7-16, Nambusunhwan-ro 364-gil, Seocho-gu,
Seoul, Republic of Korea 06739
Phone: +82-2-571-2917/18
Email: info@koreaforeign.org

# NEW STUDENT HEALTH FORM

KFS requires that your child is immunized and receives a comprehensive physical examination before attending KFS. The parent or guardian completes this page (Part 1) of the form. The Medical Provider completes Part II. Part III, Medication Authorization is ONLY for the student who needs to take medication(s) during school hours, and should be signed by the parent and the physician.

## PART I – HEALTH INFORMATION FORM

**********

Student's Name_____ Grade:_____
Last First

Student's Date of Birth:_____/_____/_____ Gender:_____

Student's Address:_____

Name of Mother or Legal Guardian:_____Phone:___-_____-_____Work or Cell:_____

Name of Father or Legal Guardian:_____Phone:___-_____-_____Work or Cell:_____

Emergency Contact:_____Phone:___-_____-_____Work or Cell:_____

**********

| Condition | Yes | Comments | Condition | Yes | Comments |
|---|---|---|---|---|---|
| ADD/ADHD | | | Hearing Problems | | |
| Anxiety Disorder | | | Heart Disorder | | |
| Chicken Pox | | | Hepatitis A/B/C | | |
| Diabetes | | | Scoliosis | | |
| Epilepsy/Seizure Disorder | | | Skin Problems | | |
| Frequent Headaches | | | Speech Difficulty | | |
| Frequent Nosebleeds | | | Vision Problems | | |
| Gastrointestinal Disorder | | | Other health concerns | | |

Describe any other important health-related information about your child (for example, hospitalizations, oxygen support, etc.):

_____

Does your child have any **allergies?** □ Yes / □ No If YES, please answer the followings:

Allergy to _____Reaction(s) the student may have_____

Treatments the student may need after exposure_____

Does your child have **asthma?** □Yes / □ No If YES, does the student use an inhaler? □Yes / □ No

If the student needs an inhaler, please indicate if the inhaler will □remain with the student or □ be provided to Nurse's Office for emergency use.

List any medication the student takes on a regular basis:_____

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# IMMUNIZATION RECORD

*KFS flows the U.S CDC immunization schedule. Please help us ensure the student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio & MMR at age 4-6 and DT/Td/Tdap at age 11-12.

*Please PRINT the exact dates (mm/dd/yr) of vaccinations received.

| Type of Vaccine | 1st Dose mm/dd/yr | 2nd Dose mm/dr/yr | 3rd Dose mm/dd/yr | 4th Dose mm/dd/yr | 5th Dose mm/dd/yr |
|---|---|---|---|---|---|
| **DPT/DTaP: Diphtheria, Tetanus, & Pertussis** | 2months | 4months | 6months | 15-18months | 4-6years |
| | / / | / / | / / | / / | / / |
| **Td/Tdap: Tetanus & Diphtheria** | 11-12 years | | | | |
| | / / | | | | |
| **Polio** | 2 months | 4months | 6-18months | 4-6years | |
| | / / | / / | / / | / / | |
| **MMR: Measles, Mumps, & Rubella** | 12-15months | 4-6years | | | |
| | / / | / / | | | |
| **Hepatitis B** | #1 | #2 | #3 | | |
| | / / | / / | / / | | |
| **Varicella: Chicken pox** | 12-15months | 4-6years | | | |
| | / / | / / | | | |

## Medication Permission

Please check the following list of common medications which School Nurse may administer to your child as needed at school.

| | | |
|---|---|---|
| Acetaminophen(Tylenol) – for pain and fever relief | □ Yes | □No |
| Ibuprofen(Burufen)- pain relief and anti-inflammatory | □ Yes | □No |
| Acetaminophen +Chlorpheniramine maleate (Habenkids)- for general cold symptoms | □ Yes | □No |
| Cetirizine(Cenoba)- for allergy | □ Yes | □No |
| Baekcho-digestive herbal syrup for Children | □ Yes | □No |
| Triprolidine HCl(Modco) – for runny nose, stuffy nose | □ Yes | □No |

## Emergency Care Permission

●Permission is hereby given for emergency measures to be taken in case of accident or sudden illness with the understanding that I will be notified as soon as possible.
●I certify that all information given on this form is complete and correct.
●I acknowledge that it is my responsibility to inform School Nurse of Korea Foreign School of any changes in my child's health, physical condition, or medical needs.

Parent Signature:_____ Print Name:_____ Date(mm/dd/yr)_____

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## PART II – PHYSICIAN'S EXAMINATION

*Medical Exam must be current-within 1 year of entry date.

Student's Name_____ Grade:_____ Student's Date of Birth:_____/_____/_____
Last First mm dd yr

Height_____ cm Weight_____ kg BMI Percentile_____ %

Vision R_____ L_____ Corrective Lens: □Yes □No

| REQUIRED TESTS | RESULT & COMMENT |
|---|---|
| Health History | |
| Physical Examination | |
| Nutritional Assessment | |
| Developmental Assessment | |
| Vision Screening | |
| Audiometric (hearing) Screening | |
| Tuberculin Test (Mantoux) **SEE BELOW** | |
| Blood Test (for anemia) | |
| Urine Test | |
| Hepatitis B | |

***MANTOUX TB SKIN TEST**:

Date given:_____ Date read:_____ Induration:_____ mm □ Negative □ Positive

A chest x-ray is required if the skin test result is positive.

Film Date_____ Person is free of communicable tuberculosis. □ Yes □ No

**********

**There were no apparent medical findings which restrict participation in routine school activities and physical education class.** □ **Yes** □ **No** If no, please explain:_____

NOTE TO THE PHYSICIAN: KFS follows the CDC immunization schedule. Please help us ensure this student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Pollio& MMR at age 4-6 and DT/Td/Tdap at age 11-12. Immunization record is on a separate form (Part I). If immunization is administered, please complete the form. Thank you.

| **Physician's Name** | **Date of Examination(mm/dd/yr)** |
|---|---|
| **Physician's Signature** | **Clinic Name&Phone Number** |

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# PART III - AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

*This Page is ONLY for the student who needs to take medication(s) during school hours.

| Student Name | Date of Birth | Division | Grade |
|---|---|---|---|
| | | | |

**********

**This Portion to be Completed by Health Care Provider/ Dentist**

Name of Medication Strength Dosage Route Time To Be Given

_____

Start date_____ Stop date_____

Diagnosis_____

If given PRN, specify the length of time between doses _____

Refrigeration required?_____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. Medication orders are good for the current school year only. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

_____ _____

Health Care Provider/ Dentist Signature Date of Signature

_____ _____

Printed Name Phone Number

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**This Portion of the Form Is To Be Completed By Parent/ Guardian**

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the health provider's prescribed instructions, not to exceed the current school year which includes summer school.

**Medication must be supplied to the school in the original container**

_____ _____

Parent/ Guardian's Signature Date of Signature

_____

Phone Number: Home/Work/Cell phone