RAMALLAH FRIENDS SCHOOL

Student Health Form

Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

PART 1 – HEALTH INFORMATION FORM

This part is to be completed by a parent:

Student's Name: _____ Current Grade: _____

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

Name of Mother: _____Cell Phone: _____ Work Phone: _____

Name of father: _____ Cell Phone: _____Work Phone: _____

In case of emergency- If parent or guardian cannot be contacted- contact the following:

1. Name : _____ Phone Number:_____

2. Name: _____ Phone Number: _____

Does the student have a history of any of the following?

	Y	N	Comments		Y	N	Comments
Allergies (Food, Insects, drugs, seasonal)				Hearing problems or Deafness			
asthma or breathing problems				Vision problems			
Diabetes				Muscle problems			
Cancer				Speech problem			
Seizure				Heart disease			
Bleeding problems				Chicken pox			
Bladder problems				Measles			
Bowel problems				Mumps			
Skin problems				Head injury, Concussions			
Developmental problems				Dental problems			
Attention- deficit/ hyperactivity disorder				Surgery			
Other serious illnesses							

Is your child on regular medication? If so, please state: _____
If your child has an allergy, please indicate possible allergic reactions and appropriate response:
_____
Specify special needs: _____
Other comments: _____

Please provide the following information for your child's record:

	Name	phone
Pediatrician		
Dentist		
Assistant (if applicable)		

PART 2- CERTIFICATION OF IMMUNIZATION

Part two and three are to be filled out and signed by the doctor.

Name of vaccine	Date of Immunization				
	1st	2nd	3rd	4th	5th
BCG					
Hepatitis B					
IPV					
DPT					
OPV					
Measles					
Hib					
MMR					
DT					
dT					
Rubella					
Other					

PART 3- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Health Assessment

Physical examination 1=Within normal 2= Abnormal finding 3= Referred for evaluation or treatment			
	1	2	3
HEENT (Head, Eyes, Ears, Nose, Throat)			
Lungs			
Heart			
Neurological			
Abdomen			
Extremities			
Skin			

Laboratory tests:

Blood type:_____

Doctor's Signature_____ Date _____