RAIN FOREST INTERNATIONAL SCHOOL **HEALTH RECORD**

SIL - B.P. 1299, Yaoundé, Cameroon

_____ _____ Date of Birth: _____/_____/____

Last Name First Name Middle Name Sex Day Month Year

_____ _____

Address Nationality

_____ _____

Father's Name Mother's Name

MEDICAL HISTORY

PERSONAL				FAMILY		
DISEASE/ILLNESS	DATE	DISEASE/ILLNESS	DATE	DISEASE/ILLNESS	YES	NO
Appendicitis		Measles, Red		Allergies		
Asthma		Meningitis		Asthma		
Chicken Pox		Parasites, Amoebic		Cancer		
Diabetes		Parasites, Other		Diabetes		
Epilepsy		Polio		Epilepsy		
Heart Trouble		Rheumatic Fever		Heart Trouble		
Hepatitis		Scarlet Fever		Tuberculosis		
Malaria		Typhoid Fever		Other		
Measles, German		Other				

ADDITIONAL HISTORY

ALLERGIES (Drug, Food, Environmental)
MEDICATIONS
PHYSICAL DISABILITIES
BLOOD TYPE: (Circle One) **O A AB B** **RH FACTOR:** (Circle One) **Negative Positive**

OTHER CONDITIONS/OPERATIONS:	PMS
Heart Murmur/Irregularities	Emotional Difficulties/Depression
Eczema	Other:

If your child requires periodic/regular medical treatment, please give details:

IMMUNIZATIONS

DISEASE	DATE GIVEN	DISEASE	DATE GIVEN
DPT (Diphtheria, Pertussis, Tetanus)		Typhoid Fever	
Polio Sabin (Oral)		Mantoux Tuberculin Test (Result)	
Measles		BCG Tuberculin Vaccine	
Mumps		Meningitis	
Tetanus		Hepatitis A	
Cholera		Hepatitis B	
Yellow Fever		Other	

Does the student wear glasses? Yes No Contact Lenses? Yes No Date prescription last changed: _____

Does the student have a hearing problem? Yes No

Does the student suffer from headaches? Yes No If so, occasionally or frequently? _____

PARTICIPATION IN PHYSICAL EDUCATION PROGRAM AND ON SPORTS TEAMS

My son/daughter, _____ , has permission to participate in the physical education program and on school sports teams at Rain Forest International School. He/she has no physical disability or health concerns that would prohibit his/her participation.

_____

Signature of Parent or Guardian

AUTHORIZATION TO ADMINISTER MEDICATION

If my son/daughter requests medication, I authorize school personnel to administer the following:

Aspirin (qty) _____ Acetaminophen (qty) _____ Ibuprofen (qty)_____ Other (qty)_____

_____
Signature of Parent or Guardian

AUTHORIZATION FOR MEDICAL CARE

In the case of accident or injury to my son/daughter _____, I authorize Rain Forest International School personnel to administer basic first aid.

I likewise authorize SIL Cameroon Branch Health Services to treat my child in the event of illness/injury, according to their discretion.

If further emergency measures are needed, I authorize school authorities to have him/her treated at the nearest emergency facility. If possible, the following location is the one I prefer. Please draw a map to that center:

_____ _____
Name and address of Emergency Care Center Signature of Parent/Guardian

---

EMERGENCY PROCEDURE

There may be a need to contact parents in case of accident or injury. Please list home phone and business phone where you may be reached in an emergency.

Home Phone_____ Father's Work Phone _____ Mother's Work Phone_____

Is there someone at home during the day if the child needs to return home in case of illness? Yes No

If so, who? _____

Please draw a map to your residence.

In case a parent cannot be reached, please write the names of two other persons in this area who will assume responsibility for this student:

1. Name _____ Home Phone _____ Work Phone _____

   Address _____

2. Name _____ Home Phone _____ Work Phone _____

   Address _____

Family Physician_____ Phone_____

Address _____