RAIN FOREST INTERNATIONAL SCHOOL rev. Apr 2023
SIL - B.P. 1299, Yaoundé, Cameroon

ANNUAL HEALTH INFORMATION FORM

This form is necessary to inform the school of your child's health status and to plan for health needs that may impact his/her school day. Information is only shared with required school staff or medical personnel as needed. For any changes to your student's health condition during the school year or questions regarding this form, please contact the school nurse or administration through the office (677.937.162).

Section A: Demographics			
Student Name: Last (Family)	First	Middle	Date of Birth DD/MM/YYYY
School Year / Grade		Sex M ☐ F ☐	Main Language Spoken at Home
Mother's Name		Phone	Email
Father's Name		Phone	Email

Section B: Emergency Contacts **In case the child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:**		
Other Emergency Contact #1:	Phone	Address
Other Emergency Contact #2:	Phone	Address

Section C: Severe or Life-Threatening Health Conditions:

Condition	Check if Yes	Comment
Severe Allergies/ Anaphylaxis	☐	☐ Foods: _____ ☐ Insect Sting: _____ ☐ Latex Epinephrine (Epi-pen) prescribed? ☐ Yes ☐ No Epinephrine (Epi-pen) injection previously given? ☐ Yes ☐ No If yes, date of injection: _____
Asthma	☐	Triggers: ☐ Exercise ☐ Environmental ☐ Upper Respiratory Infection ☐Other _____ Inhaler prescribed? ☐Yes ☐No Nebulizer Treatment prescribed? ☐Yes ☐No Number of Emergency Room visits in the last calendar year: _____
Diabetes	☐	☐ Type 1 ☐Type 2 Diagnosis Date: _____ Name of emergency medication: _____ Glucose Monitoring? ☐Yes ☐No Insulin Administration: ☐Yes ☐No
Seizures	☐	Type of Seizure: _____Date of last seizure: _____ Emergency Medication Needed at school? ☐Yes ☐No

Section D: Current Health Conditions:

Condition	Check if Yes	Comment (Please provide details)
Allergies (non-life threatening)	☐	
Blood Disorder	☐	
Cancer	☐	Currently Immunocompromised ☐Yes ☐No
Cystic Fibrosis	☐	
Dental/Oral Health Condition	☐	
Ear, Nose & Throat Condition	☐	Please specify:
Endocrine Disorder (other than Diabetes)	☐	
Food Intolerance	☐	Foods: _____ Gastrointestinal/Digestive Distress? ☐Yes ☐No
Gastrointestinal/Stomach/Bowel	☐	
Hearing Conditions	☐	
Heart/Cardiovascular	☐	
Kidney/Urinary Tract Disorders	☐	
Headache/Migraines	☐	
Lung Disease (other than Asthma)	☐	

Mobility Impairment	☐	
Muscle/Bone/Joint/Arthritis	☐	Please specify:
Neurological (other than Seizures)	☐	☐ Brain Injury/Concussion/Date Diagnosed: _____ ☐ Cerebral Palsy ☐Other: _____
Skin Condition	☐	☐ Eczema ☐ Other: _____
Vision Conditions	☐	☐Contacts/Glasses ☐ non-Correctable ☐ Other: _____
Other Health Conditions	☐	Please specify:
Emotional/Mental Health Conditions:		
ADD/ADHD	☐	Diagnosed ☐ Yes ☐ No Under treatment ☐ Yes ☐ No
Anxiety	☐	Diagnosed ☐ Yes ☐ No Under treatment ☐ Yes ☐ No
Depression	☐	Diagnosed ☐ Yes ☐ No Under treatment ☐ Yes ☐ No
Eating Disorder	☐	Diagnosed ☐ Yes ☐ No Under treatment ☐ Yes ☐ No
Other: _____	☐	Diagnosed ☐ Yes ☐ No Under treatment ☐ Yes ☐ No

Section E: Health Procedures:

If your child has a health condition, does your child require any health procedures or need any special equipment during the school days?

☐ Yes ☐ No If you answered Yes, please describe: _____

Section F: Medications
List all prescription and over-the-counter medications your child takes regularly (Home/School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			

Section G: Authorization to Administer Medication:

If my child requests medication, I authorize school personnel to administer the following medications. I will not hold RFIS or it's personnel responsible for complications related to the medication.

_____ (quantity) Ibuprofen (200 mg tablets)

_____ (quantity) Paracetamol or Acetaminophen (500 mg tablets)

Section H: Authorization for Medical Care

In the case of accident or injury to my child, I, _____, authorize Rain Forest International School personnel or SIL Cameroon Branch Health Services to administer basic first aid 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 give the location using common landmarks.

Name of Medical Center _____

Phone number _____ Name of Doctor _____

Location/Directions: _____

_____

I, _____, do authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless I withdraw it. I may withdraw my authorization at any time by contacting my child's school.

Signature of Parent/Guardian: _____ Date: _____

Printed Name of Parent/Guardian: _____

Section I: Participation in Physical Education and Sports Teams

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

Signature of Parent/Guardian: _____ Date: _____

RFIS Admin: Reviewed by School Personnel and entered into FACTS _____ (initials) _____ (date)

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IMMUNIZATION RECORD

Please complete or update the following immunization record. A copy of the immunization record listing vaccines and dates administered is also acceptable.

Check here ☐ if there have been no changes to your child's immunization record since the previous school year. If there are no changes, please do not fill out the following chart.

I understand that Rain Forest International School requires my child to be up-to-date on his/her vaccinations including:

- Diphtheria, Pertussis, Tetanus (4-5 doses by 12 years old)
- Polio (4 doses by 12 years old)
- Measles (2 doses by 12 years old)
- Mumps (2 doses by 12 years old)
- Yellow Fever (1 dose)
- Typhoid Fever (depends on the type of administration)
- Meningitis (1st dose by 12 years old; 2nd dose by 16 years old)

Student Name:					
Immunization	**Record Dates of Vaccine Doses Given (mm/yyyy)**				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP) ***	1	2	3	4	5
Diphtheria, Tetanus (DT or Tdap or Td Vaccine (given after 7 years of age) and booster every 10 years	1	2	3	4	5
Poliomyelitis Vaccine (IPV, OPV) ***	1	2	3	4	5
Measles Vaccine (Rubeola) ***	1	2			
Measles, Mumps, Rubella Vaccine (MMR) ***	1	2			
Rubella Vaccine ***	1	2			
Mumps Vaccine ***	1	2			
Yellow Fever ***	1				
Typhoid Fever ***	1	2	3		
Meningitis Vaccine *** (Meningococcal ACWY Vaccine)	1	2	3		

RFIS Admin: Reviewed by School Personnel and entered into FACTS _____ (initials) _____ (date)