International Community School

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For Office Use Only:
Reviewed By: ____________
Date: ________________
Notes: _______________

Medical History Form (Please return this form to the ICS office.)

PERSONAL DATA Date: _________________

Last Name:___________________________________ First name:_________________ Birth Date:____/____/____ (Mon Day Yr)

Sex: ☐ Male ☐ Female Race: _________________ Blood Type: ____________________

HEALTH CONDITIONS – Please check any that this child has had:

- ☐ Abnormal spinal curvature (scoliosis, etc.)
- ☐ Allergies or hay fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or wheezing
- ☐ Bedwetting at night
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer, type ____________________
- ☐ Chicken pox
- ☐ Chronic diarrhea or constipation
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Eczema
- ☐ Emotional disturbance
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent skin infections
- ☐ Frequent sore throat infections
- ☐ Heart disease, type _____________________
- ☐ Hepatitis
- ☐ Kidney disease, type __________________
- ☐ Measles (“old fashioned” or “ten day”)
- ☐ Meningitis or encephalitis
- ☐ Multiple ear infections (3 or more)
- ☐ Mumps
- ☐ Near-drowning or near-suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Poor hearing
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Seizures or epilepsy
- ☐ Sickle cell disease
- ☐ Stool soiling
- ☐ Substance abuse (alcohol, drugs)
- ☐ Suicide attempt
- ☐ Toothaches or dental infections
- ☐ Urinary tract infections
- ☐ Wetting during day

ALLERGIES – Please list and describe allergies or adverse reactions to:

Medicines/drugs: ____

Foods/plants/animals/other:____

Recommended treatment if allergies are severe: ______________________________________

INJURIES AND ILLNESSES – Please list any severe injuries or illnesses:

Injuries/Illness	Age of Child	If hospitalized (check)
________________	________________	☐ Yes ☐ No
________________	________________	☐ Yes ☐ No
________________	________________	☐ Yes ☐ No

ADDITIONAL INFORMATION

What medications are given daily? ____

What medications are given frequently, but not daily? _____________________________

This child is usually: ☐ very active ☐ normally active ☐ rather inactive

Do you have any concerns about your child’s ability to relate well with others? _____ If yes, please explain.

____

Do you have any concerns about your child’s ability to learn? _____ If yes, please explain.

____

(Over)

CERTIFICATION OF IMMUNIZATION

PART II Please attach a copy of the immunization documentation.

These five immunizations, as appropriate for child's age, are required before a child can attend ICS:

Immunizations	Vaccine Doses Administered				
DTP: Diphtheria Tetanus Pertussis	1)_____/___/____ Mo Day Yr (2 months old)	2)_____/___/____ Mo Day Yr (4 months old)	3)_____/___/____ Mo Day Yr (6 months old)	4)_____/___/____ Mo Day Yr (18 months old)	5)_____/___/____ Mo Day Yr (4-6 years old)
dT: Diphtheria Tetanus	_____/___/____ Mo Day Yr (12 years old)	_____/___/____ Mo Day Yr (every 10 years)			
☐ OPV or ☐ IPV Poliomyelitis (Please check, IPVneeds 4 doses)	1)_____/___/____ Mo Day Yr (2 months old)	2)_____/___/____ Mo Day Yr (4 months old)	3)_____/___/____ Mo Day Yr (6 months old)	4)_____/___/____ Mo Day Yr (18 months old)	5)_____/___/____ Mo Day Yr (4-6 years old)
MMR: Measles, Mumps, Rubella	1)_____/___/____ Mo Day Yr (9-12 months old)	2)_____/___/____ Mo Day Yr (4-6 years old)			
HBV: Hepatitis B Vaccine	1)_____/___/____ Mo Day Yr (at birth)	2)_____/___/____ Mo Day Yr (2 months old)	3)_____/___/____ Mo Day Yr (6 months old)		

Recommended by Thai Ministry of Public Health, but not required by ICS :

BCG vaccine: prevent from TB (tuberculosis)	_____/___/____ Mo Day Yr (at birth)				
JE:Japanese Encephalitis Vaccine	1)_____/___/____ Mo Day Yr (18 months old)	2)_____/___/____ Mo Day Yr (19 months old)	3)_____/___/____ Mo Day Yr (2 ½ years old)		

Do you have other comments or concerns about your child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, please explain briefly.

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MEDICAL SERVICE

Name of Doctor: ________________________________ Telephone: ________________________

Address: ____

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If parent/guardian is not available, I authorize the school to arrange for emergency medical treatment.
In case of minor discomfort, I authorized the school to give my child medicine at the recommended dosage.

______________________________ ______________________________

(father) (mother)

Signature of Parents