



LINCOLN SCHOOL

Student Health Form

Name of Student: _____
Last First Middle

Grade: _____ Academic Year _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: Female/ Male _____
Month Day Year

Home Phone (in Nepal): _____ Dad Mobile _____ Mom Mobile _____

STUDENT HEALTH HISTORY (To be filled in by parent)

- List all allergies your child has to food, medicine, bee stings, environmental substances, or other. Explain

Allergy:	What happens? How severe?	Medications taken for allergy?

- Does your child have asthma? Yes _____ No _____
 - Does your child use an inhaler? Yes _____ No _____
 - Does your child have any problems during physical activity with; joint or muscles pains, irregularity of heart beat, trouble breathing or coughing, heat related problems, other? Yes _____ No _____
- Explain condition: _____

- List all medicines that the student takes regularly and why, including medication for ADD etc. Include a copy of prescription from physician: _____

- Does your child suffer from travel sickness? Yes _____ No _____

MEDICATION PERMISSION

I give my permission for the School Nurse to administer the medications listed below without contacting me first. Yes _____ No _____

(Draw a line through any medication you do not want your child to be given.)

- Acetaminophen for headache or minor discomfort (other names for this are Tylenol, Panadol, Paracetamol, Crocin)
- Strepsil throat lozenges for mild sore throat
- Cough lozenges for cough drops
- Topical ointments or solutions for minor wounds, skin irritations and insect bites/ stings (Bactoban or bactrocin)

- Ibuprofen (200mg) for menstrual cramps, headaches, fever
- Stimetal (Compazine) for motion sickness
- Topical – (Pain Gay)
- Benadryl for allergic reactions
- Menstrual cramps only
- Iwash – eye cleaner

CERTIFICATIONS (Please check)

- I hereby certify that my child has my permission to travel with the school group and is physically fit and able to participate in the projected activities/ athletics.
- While I expect the school authorities to exercise reasonable precautions to avoid injury, I understand that the school has no financial obligation for any injury or illness that may occur during the travel/ activities.
- I authorize the teacher/ chaperone to administer medications as described.
- I authorize the teacher/ chaperone to attain medical treatment and care for any injury or illness that may occur during the travel/ activities.
- I further consent to emergency treatment of any sort deemed necessary by the first responding medical person. (or by any physician designated by proper school authorities) for any illness or injury that may occur during travel/ activities, and I shall not hold him/ her liable in a court of law.
- I understand that in the event of a medical emergency, every effort will be made to notify parents/ guardians as soon as possible.

Signature of Parent/ Guardian: _____ Date: _____

IMMUNIZATION HISTORY (To be filled in by a parent)

Name of Student: _____ Grade: _____

REQUIRED IMMUNIZATIONS (PARENTS OR PHYSICIAN MUST PROVIDE DATES):

Vaccinations/ Immunizations	Date Initial	Date Booster	Date Booster	Date Booster
Diphtheria, Tetanus, Pertussis __DTP or DTAP				
Measles MMR (Measles, Mumps & Rubella)				
Poliomyelitis				

TUBERCULOSIS SCREENING AND PHYSICAL EXAMINATION (Must be done by a physician or nurse practitioner or physician's assistant)

DO ONE of the following to provide evidence that the student is **free from tuberculosis**.

(1) PPD 5TU Mantoux: Date _____ Result (mm induration) _____

(2) BCG Vaccination: Date _____

(3) Chest X-ray (every 3 years): Date _____ Result _____

(4) Physician's check: Date _____ Result _____

Signature of physician or nurse practitioner or physician's assistant: _____

Date: _____