



STUDENT MEDICAL HISTORY

To be completed annually by parent.

Student name: _____ Birth date: _____
first name last name day month year

Medical Concerns	Yes	No
Skin problems		
Infectious disease		
Asthma		
Eye or ear problems		

Medical Concerns	Yes	No
Allergies		
Tuberculosis		
Epilepsy		
Migraines		

Medical Concerns	Yes	No
Diabetes		
Heart disease		
Other (please specify)		

Please provide documentation or explanation for any items marked "yes" above, including symptoms, expected reactions, and/or medication required: _____

Please provide information on any medical issues in the past of which we should be aware (e.g., fractures, burns, surgery, head injuries): _____

Current medications (name, dosage, frequency and treatment length): _____

Most medications should be kept with our school nurse so that she may supervise administration of medication. Please contact the nurse to discuss your child's medication.

The student above may:	Yes	No
Participate in competitive sports	<input type="checkbox"/>	<input type="checkbox"/>
Participate in physical education classes	<input type="checkbox"/>	<input type="checkbox"/>

Does the student have:	Yes	No
Any physical limitations?	<input type="checkbox"/>	<input type="checkbox"/>
Need of any special assistance?	<input type="checkbox"/>	<input type="checkbox"/>

Remarks: _____

Authorization

I give permission to the school nurse to give Aspirin, Panadol, Paracetamol, Tylenol, Antacids, or other non-prescription medications to my child:

Yes No

In the event of an emergency or physical injury the school administration will attempt to call parents or designated emergency contacts. Depending on circumstances, the school may contact or transport your child to one of the following medical facilities: Blue & White Clinic, Swedish Clinic, Korean Hospital, St. Gabriel's Hospital or Cure Hospital.

Should an emergency occur which involves my child, I understand that school personnel may provide First Aid and may see that s/he is given medical treatment under the direction of a physician.

I understand that ICS may require a physician's report if any problems are indicated above or observed during the school year. I understand that my child's enrollment is dependent upon the completeness and accuracy of the information provided above. I certify that all the above information is complete, true and accurate to the best of my knowledge. I understand that the information above may be shared with school staff as deemed necessary.

Parent name

Parent signature

Date

International Community School of Addis Ababa

PO Box 70282 • Mauritania Road • Old Airport
Addis Ababa • Ethiopia
tel: (251-11) 371-1544 • fax: (251-11) 371-0722
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Nurse's Office Only
Date Submitted/Updated



IMMUNIZATION HISTORY

Student name: _____ Birth date: _____
first name last name day month year

Please complete the following immunization history and submit with your application for admission. A photocopy of a WHO Immunization Booklet or other official immunization records can also be submitted.

Please keep our Nurse's Office informed of any new immunizations or vaccinations that your child receives.

Immunizations Recommended by CDC and WHO

1.	D.P.T. (Diphtheria, Pertussis, Tetanus) Three doses in first year of life, additional boosters at 18 months and preschool age.	Dates: Booster dates:
2.	T.D. (Tetanus, Diphtheria or Tetanus toxoid) For 7 years and older, booster every 10 years.	Booster dates:
3.	OPV or IPV (Oral or Inactive Polio Vaccine) Three doses in first year of life and additional booster before school age.	Dates: Booster date:
4.	MMR (Measles, Mumps and Rubella) or Rubella Before school age. Second MMR before age 11	Rubella: MMR: 2 nd MMR:
5.	Yellow Fever Required every ten years for anyone traveling to/from Ethiopia.	Dates:
6.	Meningococcal Meningitis Every three years.	Dates:
7.	Hepatitis B Series of three.	Dates:
8.	BCG (Tuberculosis vaccine) For children who have not had BCG, annual tuberculin skin test is advised.	Dates:
9.	Rabies Pre-Exposure Series of three.	Dates:
10.	Hepatitis A Vaccine	Dates:

Please update our immunization records regularly

Parent name

Parent signature

Date

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<p>Nurse's Office Only</p> <p>Date Submitted</p> <p>_____</p>
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