Student Health Form

The American School of Kinshasa
Scan and email to: registrar@tasok.net

Date of Application: / / / (Month/Day/Year)

Student Information:

Last Name | First Name | Middle Name | Preferred Name

☐ Male ☐ Female Date of Birth: / / / (Month/Day/Year)

Grade Level: _____ Starting Date at TASOK: / / / (Month/Day/Year)

Emergency Contact Information:

In the event of an emergency or medical situation in which both parents/legal guardians cannot be reached we authorize the following to be contacted:

Last Name | First Name | Relationship to Student

Cell Phone Number | Work Phone Number | Email Address

Local Doctor or Health Care Provider | Phone Number

Medical Information and Health History:

1. Is your child currently in good health? ☐ Yes ☐ No *(if no please explain)*

2. Does your child have any known ***allergies***? ☐ Yes ☐ No *(if yes please explain)*

What is the allergy to? _____

Reaction: _____

Is there a history of severe allergy or anaphylactic reaction? ☐ Yes ☐ No
Does the student carry an AAI (adrenalin auto-injector, e.g. Epipen)? ☐ Yes ☐ No

3. Does your child have asthma? ☐ Yes ☐ No Does the student carry an asthma inhaler? ☐ Yes ☐ No

4. Is the student on regular medication? ☐ Yes ☐ No

If yes, name of medication/s and frequency: _____

Does the student need to take any medication/s during school hours? ☐ Yes ☐ No
(If yes, arrangements must be made with the school nurse)

Health History:

Please indicate if your child has had any of the following conditions. If the answer is yes to any, please give details below.

	Yes	No	Age		Yes	No	Age
Diabetes				Mental Health Concerns			
Meningitis				Skin Conditions			
Tuberculosis				Excessive Bleeding			
Fainting Spells				Eye/Vision Impairment			
Heart Disorder				Wears Glasses/ Contacts			
Epilepsy				Speech Concerns			
Stomach Disorders				Ear/Hearing Difficulties			
Urinary Disorders				Other (please explain)			

Details: _____

_____

_____

_____

Parent Consent:

I give consent for my child to receive the following:

1. Minor first aid ☐ Yes ☐ No
2. Emergency care (at school with trained personnel) ☐ Yes ☐ No
3. Emergency care (at hospital Emergency Room) ☐ Yes ☐ No
4. Oral non-prescription medication ☐ Yes ☐ No

Permission is hereby given for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

I certify that all information given on this form is complete and correct.

I acknowledge that it is my responsibility to inform the TASOK School Nurse of any changes in my child's health, physical condition or medical needs.

_____ _____

Printed Name of Parent One Printed Name of Parent Two

_____ _____ Date: / / / (Month/Day/Year)

Signature of Parent One Signature of Parent Two

The American School of Kinshasa

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