School Motto: "Schutz is Family"

Schutz American School Medical Form

"The mission of Schutz American School family is to provide a premier education empowering all of our students to pursue their passions as confident global citizens."

Dear Parents,

Our school wants to provide the best possible care for your children both educationally and physically. The following form must be complete upon admission.
If you have any questions or concerns, we invite you to contact our school nurse, Sahar cellphone number 01221910230.

SECTION I: STUDENT EMERGENCY CARD

Student Information:

Student Name:	
Grade:	
Birthday:	
Address:	
Home Phone:	

Parent Information:

Mother Name:	
Mother Cellphone:	
Father Name:	
Father Cellphone:	

If Parents cannot be reached, please contact:

Contact Person I Name:	
Contact Person I Cellphone:	
Contact Person II Name:	
Contact Person II Cellphone:	

Doctor and Hospital Choice:

Doctor Name:	
Doctor Cellphone:	
Hospital Name:	
Hospital Address:	

SECTION II: HEALTH HISTORY

CONDITION	YES	NO	COMMENT	CONDITION	YES	NO	COMMENT
Allergies				Heart Problems			
Anemia				Hernia			
Asthma				Lead Poisoning			
Behavioral Problems				Nerves/Muscle Problem			
Development Problems				Nose Bleeding			
Bladder Problems				Seizures			
Bleeding Problems				Skin Problem			
Bowl Problems				Sickle Cell Disease			
Dental Problems				Speech Problems			
Diabetes				Spinal Injury			
Hearing Disorder				Surgery			
Head Injury / Concussion				Vision Problem			
Hearing Disorder				Others			

SECTION III: PHYSICAL EXAMINATION

Each year students have an eye and ear test in addition to height and weight checkup performed by the nurse.

Describe any other important health-related information about your child:

List all prescription, over-the-counter, and herbal medications your child takes regularly:

I permit the school to give my child prescribed medication: □ Yes □ No

Check here if you want to discuss confidential information with the school nurse or other school authority.

□ Yes □ No.

SECTION IIII: IMMUNIZATION

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 years)/(>7 years.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus Influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measels	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: YES ☐ When: Month:____Year:____ Verified by: _____ (Health Care Provider) Name and Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA), (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Rabies	1	2	3				
BCG	1	2	3				
PPD	1	2	3				
Yellow Fever	1						
Typhoid	1						
Other	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7

Parent/Guardian:

☐ By checking this box, I certify that all the information entered above is accurate.

Name: _____ Signature: _____ Date: _____