AMERICAN OVERSEAS SCHOOL OF ROME

ANNUAL HEALTH INFORMATION FORM

STUDENT _____,_____ **GRADE** _____
Last Name First Name
D.O.B. _____ **SEX** _____ **TEACHER (ES Student)** _____

ADDRESS _____

ALLERGIES: □ yes □ no Please specify any medications that the student takes for their allergy: _____

ASTHMA: □ yes □ no Please specify any medication required: _____

ADD/ADHD: □ yes □ no FREQUENT HEADACHES: □ yes □ no

DIABETES: □ yes □ no SEIZURE DISORDER: □ yes □ no Specify what kind: _____

_____Does your child require an Epi-pen or other medication for severe allergic reactions?

_____ Has your child ever had to use an Epi-pen before for a severe allergic reaction? How long ago? _____

_____ Does your child have any condition that would limit physical education activities? _____

_____ Does your child take any prescribed medication(s)? Please List: _____

_____ Does your child have any other medical concerns we should be aware of? If so, please describe: _____

_____

EMERGENCY CONTACT INFORMATION (If Parents are not reachable)

1) Name_____ Phone (Home) _____

(Cell)_____ (Work) _____

2) Name_____ Phone (Home) _____

(Cell)_____ (Work) _____

In the event that a parent cannot be reached, the school has my permission to take appropriate emergency medical action and have the student transported to the nearest hospital.

Parent Signature _____ **Date** _____

In non-emergency health concerns (headaches, cramps, indigestion), I authorize the school nurse to administer fever-reducing/pain killer medication and/or antacids if the need arises i.e. Tylenol, Advil, Tachipirina, TUMS or generic according to the recommended dosage.

Parent Signature _____ **Date** _____

NOTE: Please attach a complete and current vaccination record. For any questions, please contact the school nurse by sending an email to nurse@aosr.org

IMMUNIZATIONS REQUIRED:

Poliomyelitis

Diphteria

Tetanus

Pertussis

Haemophilus Influenzae Type B Infection

Hepatitis B

Measles

Mumps

Rubella

Varicella