

# Grace International School

## Confidential Staff Medical & Emergency Record Form

### 2006-2007

**Family Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

A completed *Medical Record Form* is required yearly. It must be submitted to the Nursing Office at the start of the first semester each year. The information provided will remain confidential and be used by the school nurse to assist you should a need arise at school. For this reason it is important that the information provided is accurate.

**ALLERGIES (Drug, Food, and Other)**

**Are you allergic to any drugs, food or medications?**  No  Yes (if yes, please specify substance and reaction): \_\_\_\_\_

**Blood Type:** \_\_\_\_\_ **Are you willing or able to donate blood:**  Yes  No

<b>Medical History</b> Please indicate (X) if you previously or currently have/had any of the following:									
	Past	Now		Past	Now		Past	Now	
<b>Heart or Circulation Problems:</b>									
Blood Pressure: High Low			Anemia			Fainting			
Heart condition (specify: )			Rheumatic Fever			Other (specify: )			
<b>Digestive Tract Problems:</b>									
Chronic diarrhea			Chronic constipation			Frequent stomach aches			
Other (specify: )									
<b>Respiratory Problems:</b>									
Asthma: rare/occasional/frequent			Tuberculosis (TB)			Other (specify: )			
<b>Endocrine Problems:</b>									
Diabetes			Thyroid problems (specify: )			Other (specify: )			
<b>Nervous System Problems:</b>									
Meningitis/encephalitis			Epilepsy			Seizures (e.g. febrile)			
Twitches/tics (specify: )			Head injury			Frequent headaches			
Other (specify: )									
<b>Immune problems:</b>									
HIV			Other (specify: )						
<b>Muscular/Skeletal problems:</b>									
Fracture (specify: )			Scoliosis			Other (specify: )			
<b>Emotional/Behavioral Problem:</b>									
Mental health issue (specify: )			Behavior problem (specify: )			Suicide attempt			
Substance abuse (specify: )			Other (specify: )						
<b>Genetic/Congenital Problem:</b>									
Thalassemia			Sickle Cell anemia			Hemophilia			
Cerebral palsy			Other (specify: )						
<b>Genital/Urinary Problems</b>									
Sexually Transmitted Disease (specify: )			Recurrent UTI's			Pregnancy			
			Kidney disease (specify: )			Other (specify: )			
<b>Sensory problems:</b>									
Ear/hearing problems (specify: )			Eye/vision problems (specify: )			Learning Disability (specify:)			

*Please complete additional sheet if necessary for any problems that you marked.*

**Have you ever been hospitalised?** [ ] no [ ] yes (please specify date and cause): \_\_\_\_\_

**Comments or concerns about your health or medical history that you would like the school nurse to be aware of when caring for you:**

This assignment may require frequent stair climbing and walking at an incline. Do you have any physical limitations which would prevent you from climbing stairs or walking moderate distance on an incline?  Yes  No

If yes, please describe: \_\_\_\_\_

**CURRENT MEDICATIONS**

What medicines do you take regularly? \_\_\_\_\_

TB testing is required by Grace International School. We accept a negative TB skin test yearly; or a negative chest x-ray every three years.

*NOTE: While Grace International School does not at this time require immunizations, we strongly recommends that you keep up to date with your immunizations for your personal health as well as that of others. Please consult your physician or visit [www.who.int/ith/en](http://www.who.int/ith/en) for recommended immunizations for Thailand. Please submit a copy of your immunization records to GIS.*

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**EMERGENCY INFORMATION**

<u>Emergency Contact in Thailand - #1</u>	<u>Relationship</u>	<u>Phone Number</u>
<u>Emergency Contact in Thailand - #2</u>	<u>Relationship</u>	<u>Phone Number</u>
<u>Emergency Contact Name – Home Country</u>	<u>Relationship</u>	<u>Phone Number</u>

In case of accident or other emergency, I authorize the school to arrange for emergency medical treatment. **I understand that I will be taken to Ram 1 Hospital for treatment.**

My personal physician (in Thailand - if known) is \_\_\_\_\_; phone number \_\_\_\_\_.

Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

**INSURANCE INFORMATION**

I am not covered by medical insurance       I am covered by medical insurance

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip Code \_\_\_\_\_

Country \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Since I have medical coverage as shown above, I waive coverage by the Grace medical insurance program knowing that such a waiver will continue throughout my enrollment or until I request to be considered at a later date.

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_