



Saigon South International School

Nguyen Van Linh Ave., Tan Phong, District 7,
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STUDENT HEALTH FORM.

*This form will be given after a student is accepted. It must be completed and returned to the SSIS prior to school attendance.
All the information must be in English.*

Name: _____ **Grade:** _____
Last First Preferred name

D.O.B: _____ **Sex:** _____ **Nationality:** _____
dd / mm / yy

EMERGENCY CONTACTS:

Name: _____
Last First Relation to student

Phone (home): _____ Phone (work): _____ Mobile: _____

Name: _____
Last First Relation to student

Phone (home): _____ Phone (work): _____ Mobile: _____

Name: _____
Last First Relation to student

Phone (home): _____ Phone (work): _____ Mobile: _____

MEDICAL EMERGENCY AUTHORIZATION:

- I authorize SSIS to refer my child to a hospital for urgent treatment in case the above emergency contacts can not be reached. I shall bear financial responsibility for any such treatment.
- Permission for minor medications : Advil (Ibuprofen), Acetaminophen (Tylenol), Anti-histamine (Benadryl, Actifed, Clarityne), Antacid (Maalox), Throat lozenges : YES NO

Parent 's name in print: _____ Parent 's signature: _____

Date: _____
Day / Month / Year

STUDENT HEALTH HISTORY

Student Name:

_____ Last name

_____ First name

_____ Preferred name

| Infectious disease history | | | Health problems / issues / doctor 's diagnosis | | |
|----------------------------|----|---------------|--|----|----------------|
| | NO | YES(give age) | | NO | YES (give age) |
| Rheumatic fever | | | Vision problem | | |
| Chicken pox | | | Hearing loss | | |
| German measles | | | Seizure disorder | | |
| Measles | | | Heart disease | | |
| Mumps | | | Diabetes | | |
| Scarlet fever | | | Orthopedic | | |
| Chronic ear infection | | | Asthma | | |
| Urinary tract infection | | | ADD / ADHD | | |
| Glandular fever | | | Other(s) | | |

Serious illnesses / operations / injuries / disabilities (Please specify):

Medications taken regularly (include prescription and over the counter medications):

Medication

Dosage

Reason

Frequency

Allergies (to food, medicine, insect stings or environment):

PHYSICAL EXAMINATION (To be completed by a medical doctor)

| | | | | | |
|----------------|-------------------|----------------|-------|------------|-------|
| Height | _____ | Weight | _____ | BMI | _____ |
| Blood group | _____ | Blood Pressure | _____ | Heart rate | _____ |
| Vision acuity | Right eye : _____ | | | Left eye : | _____ |
| Hearing acuity | Right ear : _____ | | | Left ear : | _____ |

Immunization History : Please review and transcribe dates of immunizations from immunization records.

| Vaccine | Date of immunization (dd / mm / yy) | | | | |
|---|--------------------------------------|-----------------|-----------------|-----------------|-----------------|
| | 1 st | 2 nd | 3 rd | 4 th | 5 th |
| Polio (OPV / IPV) | | | | | |
| Diphtheria, Tetanus, Pertussis (DTP / DTaP) | | | | | |
| Tetanus, diphtheria (Td) | | | | | |
| Tetanus, diphtheria, pertussis (Tdap) | | | | | |
| Measles, Mumps, Rubella (MMR) | | | | | |
| Haemophilus influenza type b (Hib) | | | | | |
| Hepatitis A | | | | | |
| Hepatitis B | | | | | |
| Varicella | | | | | |
| Meningococcal A + C | | | | | |
| Japanese Encephalitis | | | | | |
| Typhoid | | | | | |
| Human papillomavirus vaccine HPV | | | | | |
| Other(s) | | | | | |

Tuberculosis screening : Please provide documentation for one of the following:

BCG vaccine within 05 years

Given date (dd/mm/yy) _____

Mantoux / PPD test

Date(dd/mm/yy) _____

Result _____

Chest Xray

Date(dd/mm/yy) _____

Result _____

Physical Examination :

| | Normal | Abnormal | Comments on abnormalities |
|------------------------------|--------|----------|---------------------------|
| Neurological | | | |
| Cardiology | | | |
| Respiratory | | | |
| Musculo-skeletal system | | | |
| Gastrointestinal | | | |
| Integumentary | | | |
| Urological | | | |
| Attention Deficit Disorder | | | |
| Endocrinology | | | |
| E.N.T. (Ear – Nose – Throat) | | | |
| Blood disorders | | | |
| Other(s) | | | |

Special medical requirement at school (if any) _____

| Recommendations for Physical Education activities | YES | NO |
|---|-------------------------|-----------------------|
| Competitive activities | | |
| Regular activities | | Please specify if NO: |
| Restricted activities | Please specify if YES : | |

Date of examination: _____
 Day / Month / Year

Physician's name in print: _____

Physician's address & Tel # _____

Physician's signature & stamp _____

Guidance on Student Health form.

The health form must be completed and returned the SSIS prior to school attendance. All the information must be in English.

Indicated hospitals / clinics in Ho Chi Minh City: Your child can have the physical examination done at one of the following indicated hospitals / clinics:

1. Franco Vietnamese Hospital (FVH) : Nguyen Luong Bang St., District 7. Tel : 84 8 5411 3333
2. Medical Family Practice : 34 Le Duan St., District 1 – Diamond Plaza building. Tel : 84 8 3822 7848
3. Columbia Asia International Clinic : 08 Alexandre De Rhodes St., District 1. Tel : 84 8 3823 8888
4. International SOS Clinic : 65 Nguyen Du St., District 1. Tel : 84 8 3829 8520
5. Victoria International Healthcare : 79 Dien Bien Phu St., District 1. Tel : 84 8 3910 4545
6. Hong Duc hospital: 234 Pasteur St., District 1. Tel : 84 8 3829 3159

Immunization history: You have to show your child ‘s immunization record to the physician, who will check and transcribe accurately. Otherwise, the immunization record copy is required to submit with the health form. The SSIS Immunization requirements base on CDC ‘s Immunization Schedule as below:

| Vaccine ▼ | 1 st shot | 2 nd shot | 3 rd shot | 4 th shot | 5 th shot |
|---|---|--|----------------------|----------------------|----------------------|
| Hepatitis B (Hep B) | At birth | 1 – 2 months old | 6 – 18 months old | | |
| Diphtheris, Tetanus Pertussis (DTaP) | 02 months old | 04 months old | 06 months old | 15 – 18 months old | 4 – 6 years |
| Haemophilus influenza type B (Hib) | 02 months old | 04 months old | 06 months old | | |
| Pneumococcal (PCV) | 02 months old | 04 months old | 06 months old | 15 – 18 months old | |
| Inactivated Poliovirus IPV | 02 months old | 04 months old | 06 – 18 months old | 4 – 6 years | |
| Measles, Mumps, Rubella MMR | 12 – 15 months old | 4 – 6 years | | | |
| Varicella (Chicken pox) | 12 – 15 months old | 4 – 6 years | | | |
| Hepatitis A (Hep A) | 12 – 23 months | 6 months after the 1 st shot. | | | |
| Tetanus, diphtheria toxoids & acellular pertussis (Tdap) | Between 11 – 12 years old. Or between 13 – 18 years old. | | | | |

Tuberculosis screening:

Tuberculosis screening is required to rule out active TB infection. Please provide documentation of one of the following:

1. BCG vaccine within 05 years.
2. Mantoux or PPD skin test results.
3. Chest X-ray results.

Exemption from meeting the immunization requirement:

If a child is exempted from meeting the immunization requirement for medical reasons, a doctor ‘s written statement is required. The statement must include:

1. Which immunization(s) is to be exempted.
2. The specific nature of the medical condition and probable duration of the medical condition.
3. Probable duration of the medical condition.