



# Saigon South International School

Nguyen Van Linh Ave., Tan Phong, District 7,

Ho Chi Minh City, Vietnam.

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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:

1. 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.
2. 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 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
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)					



## 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 <sup>st</sup> shot	2 <sup>nd</sup> shot	3 <sup>rd</sup> shot	4 <sup>th</sup> shot	5 <sup>th</sup> shot
<b>Hepatitis B (Hep B)</b>	At birth	1 – 2 months old	6 – 18 months old		
<b>Diphtheris, Tetanus Pertussis (DTaP)</b>	02 months old	04 months old	06 months old	15 – 18 months old	4 – 6 years
<b>Haemophilus influenza type B (Hib)</b>	02 months old	04 months old	06 months old		
<b>Pneumococcal (PCV)</b>	02 months old	04 months old	06 months old	15 – 18 months old	
<b>Inactivated Poliovirus IPV</b>	02 months old	04 months old	06 – 18 months old	4 – 6 years	
<b>Measles, Mumps, Rubella MMR</b>	12 – 15 months old	4 – 6 years			
<b>Varicella (Chicken pox)</b>	12 – 15 months old	4 – 6 years			
<b>Hepatitis A (Hep A)</b>	12 – 23 months	6 months after the 1 <sup>st</sup> shot.			
<b>Tetanus, diphtheria toxoids &amp; acellular pertussis (Tdap)</b>	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.