# Faith International Academy

## HEALTH INVENTORY

*PARENTS, please fill out this sheet as completely as possible. This information will be treated as confidential and will assist the Health Services.*

**Today's Date:** _____

Student Passport Name: _____ Gender: _____ Grade *(in which enrolling)*: _____
Name Used: _____ Student's Birth Date: _____ Birthplace: _____
Father's Name: _____ Father's Birthplace: _____
Mother's Name: _____ Mother's Birthplace: _____
Home Address: _____ Home Phone: _____
Father's Contact #: _____ Mother's Contact #: _____
Mission or Business Name: _____ Phone #: _____
Mission or Business Address: _____

**IMMUNIZATION HISTORY**

*List dates of immunizations and tests which your child has received. This form will not be accepted without this information. When writing dates, please use the following order: MONTH, DAY, YEAR.*

***DPT, Polio, and MMR are required for entrance into school**

| | | | | | |
|---|---|---|---|---|---|
| Diphtheria-Pertusses-Tetanus (DPT) | | | | | |
| Diphtheria-Tetanus (Td) | | | | | |
| M M R | | | | | |
| Polio (O=oral I=injection) | | | | | |
| Tetanus Toxoid | | | | | |
| B C G | | | | | |
| Chicken Pox (Varicella) | | | | | |
| Hepatitis A | | | | | |
| Hepatitis B | | | | | |
| H P V | | | | | |
| Influenza | | | | | |
| Meningoccocal vaccine | | | | | |
| Rabies | | | | | |
| OTHERS | | | | | |
| | | | | | |
| | | | | | |

Tuberculin Skin Test Date: _____ Result: _____
Date: _____ Result: _____
Chest X-Ray Date: _____ Result: _____
Date: _____ Result: _____
TB Treatment Dates: _____ Medications: _____

**MEDICAL HISTORY**

| | Family Health History |
|---|---|
| Father | |
| Mother | |
| Siblings | |

********Please complete important health information on reverse side….***

Give approximate dates of any of the following diseases that your child has experienced:

| | | |
|---|---|---|
| Ameobic Dysentery | Malaria | Typhoid Fever |
| Bacillary Dysentery | Measles | Diphtheria |
| Chicken pox | Meningitis | Diabetes |
| Cholera | Mononucleosis | Bleeding Disorders |
| Dengue Fever | Mumps | Other |
| Pneumonia | Hepatitis | Other |
| German Measles | Rheumatic Fever | Asthma |
| Epilepsy | Scarlet Fever | |
| Surgeries | Tuberculosis | Learning Disabilities |

Is your child currently under medical care for any of the above: ☐ **No** ☐ **Yes.** If yes, explain. *(Include name of physician)*

Is your child taking any medications on a regular basis? ☐ **No** ☐ **Yes.** If yes, what?

Does your child have any allergies? ☐ **No** ☐ **Yes, to medications** ☐ **Yes, others.** If Yes, please list allergies and reactions:

Has your child ever had a head injury requiring medical or surgical treatment? ☐ **No** ☐ **Yes.** If yes, give date, details, and treatment:

Is there anything else we need to know about your child that may affect them while at school?