



Faith International Academy

HEALTH & IMMUNIZATION INVENTORY

The Above Information Is Considered Confidential. It Will Be Shared With School Staff As Needed During The Time Your Child Is Enrolled In Faith International Academy In Order To Ensure The Health And Safety Of Your Child, Unless Otherwise Requested By You In Writing.

In Case Of Emergency, I Give Permission For School Personnel To Call 911 Davao Or Transport My Child To The Nearest Hospital.

Today's Date: _____ Grade Applying: _____
 Student Passport Name: _____ Name Used: _____ Gender: _____
 Student's Birth Date: _____ Birthplace: _____
 Father's Name: _____ Father's Birthplace: _____
 Mother's Name: _____ Mother's Birthplace: _____
 Father's Contact #: _____ Mother's Contact #: _____
 Home Address: _____ Home Phone: _____
 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-Pertussis-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 | | | | | |
| Meningococcal Vaccine | | | | | |
| Rabies | | | | | |
| OTHERS | | | | | |
| | | | | | |

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

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 |

Does your child have any of the following health conditions?

- No Yes Allergy to food, what food? _____
- No Yes Allergy to bees? _____
- No Yes Allergy to peanuts? _____
- No Yes Allergy to medication or others, please specify _____

Medication at school:

FIA requires written permission from the parent/guardian before any medication (prescription or over the counter) can be given at school.

- No Yes Daily medicine at school
- No Yes "As needed" medicine at school (i.e. paracetamol, ibuprofen, omeprazole, loperamide, cetirizine)

Name of Medications: _____

Does your child have any other conditions that would affect his/her classroom performance or P.E. activities?

- No Yes Glasses _____
- No Yes Hearing aides _____
- Others _____

Is your child currently under regular medical care for: No Yes.

If yes, please explain. (Include name of physician)

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

Has your child ever had a head injury requiring medical or surgical treatment? No Yes.

If yes, please give date, details, and treatment:

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