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HEALTH FORM

STUDENT INFORMATION

Full Legal Name: _____
(*Last Name,* *First Name,* *Middle Name*)
Nickname: _____ **Gender:** _____
Date of Birth: _____ **Age:** _____ **Place of Birth:** _____
MM/DD/YYYY
Citizenship: _____ **Passport Number:** _____
Home Address: _____
Home Phone: _____ **Mobile Phone:** _____
Father's Name: _____ **Mobile Phone:** _____
Mother's Name: _____ **Mobile Phone:** _____

Other person(s) to contact in case of emergency:

Names	Relationship to Student	Phone Numbers
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH RECORD

Please submit copies of immunization and other pertinent medical records.
_____ Immunization Record _____ COVID Vaccine Record _____Medical Record

Pediatrician: _____

Telephone # _____

Mobile # _____

Clinic Address _____

HEALTH HISTORY

Medical History
1. Does the child have any existing medical conditions? [ ] Yes [ ] No If yes, please specify
2. Is the child under a physician's care now? [ ] Yes [ ] No If yes, please elaborate:
3. Has the child ever been hospitalized or had a major operation? [ ] Yes [ ] No If yes, please indicate the reason:
4. Is he/she taking any medications, pills, or drugs? [ ] Yes [ ] No If yes, please specify:
5. Is the child under any kind of medical treatment or therapy? [ ] Yes [ ] No If yes, please specify:

Note: If you have answered YES to any number from 1-5, kindly attach a Medical Certificate or Clearance from the physician indicating the diagnosis.

Allergies

1. Does the child have allergies to medication? [ ] Yes [ ] No
If yes, please specify:

2. Does the child have food allergies? [ ] Yes [ ] No
If yes, please specify:

3. Does the child have any other kind or form of allergies not listed above? [ ] Yes [ ] No
If yes, please specify:

COVID-19 History

Has the child ever been infected with Covid-19? [ ] Yes [ ] No

If yes, please indicate when: *(MM-DD-YY))*

[ ] Asymptomatic [ ] Mild [ ] Severe

For those who have been infected by Covid-19 more than once, please elaborate below:

Beginning with the most recent

Date:_____

[ ] Asymptomatic [ ] Mild. [ ] Severe

Date:_____

[ ] Asymptomatic [ ] Mild. [ ] Severe

Date:_____

[ ] Asymptomatic [ ] Mild. [ ] Severe

Date:_____

[ ] Asymptomatic [ ] Mild. [ ] Severe

Date:_____

[ ] Asymptomatic [ ] Mild. [ ] Severe

COVID-19 VACCINATION STATUS

Please indicate the required information on the student's Covid-19 Vaccination status. Please check the appropriate box.

- ☐ Unvaccinated
- ☐ Partially Vaccinated
- ☐ Fully Vaccinated
- ☐ First Booster Received
- ☐ Second Booster Received

If fully or partially vaccinated, please indicate the following information:

Dose Number	Brand/ Manufacturer	Date
First Dose		
Second Dose		
First Booster Received		
Second Booster Received		

If not yet vaccinated, please indicate the reason the child has not yet taken/cannot take the Covid-19 vaccine:

_____
_____
_____
_____
_____
_____
_____
_____

My signature below certifies that I have answered this form to the best of my knowledge and belief and that all information I give in this Health Form is true and correct.

I authorize Reach International School to investigate all the statements contained in this form.

Parent/Guardian Name and Signature	Date