ST. STEPHEN'S SCHOOL HEALTH RECORD

Via Aventina 3 – 00153 Roma, Italy **Phone**: +39 065750605 **Fax**: +39 065741941 **Email**: ststephens@ststephens-rome.com

Name: ______________________________ **Date of Birth:** _________ **Gender:** ______
Last name First name MM-DD-YYYY

	Mother	Father
Home Address		
Home Telephone		
Work Telephone		
Cellular		

Emergency Contact Person(s):

Name/Relationship	Telephone: Work and Home	Telephone: Cellular

Family Doctor's name: __________________________ **Telephone:** ____________________

MEDICAL HISTORY: (To be filled out by Parents. Check, giving approximate dates)

Childhood Diseases:		Dates
Scarlet Fever		
Chicken Pox		
German Measles		
Whooping Cough		
Mumps		
Poliomyelitis		
Diphtheria		

Other ________________

Chronic Diseases:		Dates	Medication
Asthma			
Kidney Disease			
Diabetes			
Heart Trouble			
Convulsion –Epilepsy			
Blood disorders			
Fainting			
Frequent nose bleeds			
GI problems			

Acute Diseases:		Dates
Frequent colds		
Bronchitis		
Frequent sore throat		
Sinusitis		
Abscessed Ears		
Hepatitis A B C		
Mononucleosis		

Other ________________

Please list any medication your child takes regularly or seasonally and give reasons:

____

ALLERGIES/INTOLERANCE:

My child is allergic to: ____
(please enclose copy of medical certificate)

My child is intolerant to: ____
(please enclose copy of medical certificate)

In case of my child suffering from mild illness such as headache or high fever, I give permission for Paracetamol (Tachipirina) to be given by the school nurse

Parent's Signature ______________________________ Date ______________________

I ___________________________ hereby authorize the use of personal data (in accordance to d.lgs. n° 196 of 1003) in order to safeguard the health of my child and the school community

Parent's Signature ______________________________ Date ______________________

Please answer all of the following questions:

Does your child have impaired vision? **YES/NO** Wear glasses or contact lenses? **YES/NO**

Does your child have impaired hearing? **YES/NO** Does your child have speech defect? **YES/NO**

Does your child have physical handicap? **YES/NO** If yes, please specify: ______________________________________

Is your child able to participate fully in the Physical Education Program? **YES/NO**
If not, please include a letter from your family physician giving details as to the degree of limitation

Has your child ever been under the care of a Psychiatrist or Psychologist? **YES/NO**
If yes, please give further information: ____

IMMUNIZATION RECORD			
Required by Italian Law	**Date of last Immunization**	**Other**	**Date of last Immunization**
Diphtheria		MMR	
Tetanus		Mumps	
Polio		Measles	
Hepatitis		Rubella	
		Tuberculosis test	

List dates and reasons for past hospitalizations and/or operations

- ____
- ____
- ____

Boarding students should also enclose a copy of the student's passport and Health Insurance

PHYSICAL EXAMINATION: (To be filled out by licensed physician)

Height_________ Weight __________ Blood Pressure _______ /_______ Pulse __________

Eyes: (R)______ (L) ______ Ears: (R)_______ (L)_______ Allergies: ____________________
Nose: ___________________ Throat: _________________ Blood group: ________________
Teeth: __________________ Heart: __________________ Lungs: ______________________
Abdomen: _______________ Extremities: _____________ Posture (spine): _____________
Hernia: _________________ Skin: ____________________ Genitalia: ___________________
Menstrual History: ____________________

Recommendation and Restrictions:
General appraisal: ____
Examining physician: ____
Address & Telephone: ____
Date: _______________

MEDICAL AUTHORIZATION: (To be filled out by parent or guardian)

Student's Name: ____
Address: ____ Tel. ______________________
Hospital preference (if any): ____

In case of medical emergency, I understand that all efforts will be made to contact parents or guardian: If I cannot be reached, I authorize the school to give or obtain the necessary medical attention or surgery where possible from the physician or hospital named above, otherwise as the emergency demands. I agree to assume all medical expenses involved. (If none of the above can be contacted, one of the school's doctors will be contacted).

I hereby also give my consent that my child named above participate in all regular school physical activities with the following exceptions: ____
I understand that it is my responsibility to communicate in writing to the Nurse any changes to the information given on this form.

Parent's Signature ___________________________________ Date ____________________________