

INTERNATIONAL SCHOOL OF BOSTON 2010-2011: HEALTH OFFICE INFORMATION CARD

Name of Student _____	Date of Birth _____
Grade _____ Nationality _____	First Language _____

With whom does the student live? Father () Mother () Both () Caregiver ()
 Who should be contacted in the event of a medical emergency? List in order of preference.
 Father () Mother () Caregiver () Relative/Friend ()

Father's Name _____ Home Phone _____
 Home Address _____ Work Phone _____
 _____ Cell Phone _____

Mother's Name _____ Home Phone _____
 Home Address _____ Work Phone _____
 _____ Cell Phone _____

Caregiver's Name _____ Home Phone _____
 Home Address _____ Work Phone _____
 _____ Cell Phone _____

If a medical emergency situation should arise the school should contact the following *locally based* individuals if the parent/guardian cannot be reached.

Please be sure that these individuals are aware that they have been listed.

() Relative or Friend's Name _____ Phone Number _____
 () Relative or Friend's Name _____ Phone Number _____

Please notify the school and school nurse if any information on this card changes!
(Please complete both sides of this card and sign and date where designated)

Place recent student photo here

(New students only)

Pediatrician's Name _____ Phone Number _____

Dentist's Name _____ Phone Number _____

Preferred Hospital (if possible) _____ Health Insurance Provider and policy number _____

I authorize the school nurse to administer the following medications to my child according to school medication protocol.

Tylenol	Yes _____	No _____	* Signature _____	*Date _____
Motrin	Yes _____	No _____	*Signature _____	*Date _____
Benadryl	Yes _____	No _____	*Signature _____	*Date _____
Calamine lotion	Yes _____	No _____	*Signature _____	*Date _____
Hydrocortisone	Yes _____	No _____	* Signature _____	*Date _____
Bacitracin	Yes _____	No _____	*Signature _____	*Date _____

Routine Medications/Amounts & Times at Home _____

All prescription and non-prescription medications must be in pharmacy labeled bottle and kept in the Health Office.

Allergies

My child has no known allergies *Signature _____ *Date _____

My child is allergic to: (Food, drug, insects, other)	Describe Reaction	Describe Treatment

Asthma: Yes () No () Inhaler sent to Health Office for my child: Yes () No ()

Epi-pen needed Yes () No () 2 epi-pens sent for my child Yes () No (); one for lunch room, one for health office

My child has had the following major illnesses _____

My child has had the following major surgeries _____

I have read and understood the school's policy on allergies and the School Health Services brochure outlining procedures for administration of medications and guidelines for when a child should be kept home from school .

*Signature _____

*Date _____