MEDICAL CARD

Academic Year 2023-2024

International School of Havana

STUDENT INFORMATION

Name: _____

Age: _____ Date of Birth: ____/ _____/ _____ Home telephone: _____
Day Month Year

Address: _____

_____

PARENTS INFORMATION

(Please write in BLOCK letters)

Parent 1 / Caregiver 1 full name: _____

Parent 2 / Caregiver 2 full name: _____

IN CASE OF EMERGENCY

Person in charge: _____

_____

Home telephone: _____ Cellular phone: _____

Office telephone: _____

Name of Physician/Doctor: _____

Telephone: _____ Email: _____

In an emergency when the parents cannot be contacted, who should we notify? Please include the person´s telephone number.

_____

_____

In case of emergency, and in case the parents cannot be contacted, what hospital should we take your son/daughter to?

_____

Please sign to indicate that you authorize the school to act in an emergency if you cannot be contacted

_____

In what hospital do you have your medical insurance coverage? _____

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HAS YOUR CHILD HAD OR IS CURRENTLY SUFFERING FROM ANY ILLNESSES?

Please check the corresponding box

CHICKENPOX ( ) HEPATITIS ( ) MEASLES ( ) MUMPS ( ) BRONCHIAL ASTHMA ( ) CONVULSIVE SYNDROME ( ) EPISTAXIS (Frequent nose bleeding) ( )

SURGERIES ( ) Specify _____ OTHER ( ) Specify _____

PLEASE CHECK THE CORRESPONDING BOX

ALLERGIES: to MEDICATION ( ) to INSECT BITES ( ) to FOOD ( )

OTHER ( ) Specify the type of allergy: _____

IS YOUR CHILD ON SPECIAL MEDICATION: YES ( ) NO ( )

Specify the type of medication being taken and why:

PHYSICAL EXAM – TO BE FILLED OUT BY THE DOCTOR

WEIGHT _____ HEIGHT _____ BLOOD GROUP _____

NEUROLOGICAL EXAM _____ EYE SIGHT _____

OTHER CONDITIONS: _____

VACCINATION HISTORY (PLEASE RECORD THE DATE OF LAST VACCINATION)

DPT _____ POLIO

MEASLES _____ FLU (INFLUENZA)

HEPATITIS _____ M.M.R. (Measles, Mumps, Rubella)

CHICKENPOX _____ CHOLERA

OTHER:

_____ _____

NAME OF DOCTOR SIGNATURE AND STAMP

DATE: _____ PARENTS / CAREGIVERS SIGNATURE: _____

Note: ***Please attach to this form a copy of the vaccination record for students from 2 and a half to 7 years old.***

SCHOOL USE ONLY

Medical Card received by_____ Date_____

Observations: