Netherlands International School Lagos

Student Health Report

STUDENT NAME: _____ YEAR/ GRP: _____

In order to keep your child's health records current, please complete this form and either return it to the registrar or email to info@nislagos.org, together with your enrolment form. The information provided will offer considerable assistance to the NISL team when dealing with acute/emergency and chronic health problems should they arise during school hours.

1. **ALERTS:** *please check those that apply*

☐ **NONE** ☐ **Diabetes** ☐ **Heart condition**

☐ **Autism** ☐ **Dietary restrictions** ☐ **Migraines**

☐ **Asthmatic** ☐ **Epileptic** ☐ **Sickle cell anemia**

☐ **Cerebral Palsy** ☐ **Excessive bleeding** ☐ **Seizures/ convulsions**

☐ **Constant nose bleeds** ☐ **Other: please explain:** _____

☐ **Cystic Fibrosis**

2. **Allergies:** *please check all those that apply*

☐ **NONE** ☐ **Grass** ☐ **Penicillin**

☐ **Dairy products** ☐ **Bees/ wasps/ insects** ☐ **Pollen**

☐ **Dust** ☐ **Medications/drugs** ☐ **Shellfish**

☐ **Eggs** ☐ **Peanuts** ☐ **Sulphur products**

☐ **Fish** *Other: please explain:* _____

3. **FRACTURES AND INJURIES**

☐ **NONE** *If Yes, please explain*_____

4. **RECENT HOSPITALISATION**

☐ **NONE** *If yes, please explain*_____

5. OPERATIONS/ PROCEDURES

☐ **NONE** *If yes, please explain*_____

6. AUDITORY DIFFICULTIES: *please check those that apply*

☐ **NONE** ☐ **Ear Infections** ☐ **Hearing aid(s)** ☐ **Deafness**

Other: please explain_____

7. DENTAL DIFFICULTIES

☐ **NONE** *If yes, please explain*_____

8. PHYSICAL DIFFICULTIES

☐ **NONE** ☐ **Limitations to physical activities** *If yes, please explain*_____

9. VISUAL DIFFICULTIES: *please check those that apply*

☐ **NONE** ☐ **Contacts** ☐ **Blindness**

☐ **Glasses** *Other: please explain*_____

10. PRESENT MEDICATIONS: *please check those that apply*

☐ **NONE** ☐ **Physical** ☐ **Psychological**

☐ **Occupational** *Other: please explain*_____

11. **THERAPY/TREATMENTS:** *please check those that apply*

☐ **NONE** ☐ **Physical** ☐ **Psychological**

☐ **Occupational** *Other: please explain*_____

12. OTHER RELEVANT INFORMATION: *please give details where appropriate*

VACCINATION RECORD

VACCINES	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Diptheria and tetanus DTap, DPT, DT, TD				
Measles, mumps, Rubella				
Hep A				
Hep B				
HIB				
Varicella				
Yellow Fever				
Meningococcal				
Pneumoccocal				
BCG				
Other: Please list				
Other: Please list				

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