

# MEDICAL HISTORY – International Students

20\_\_-20\_\_ School Year

Please Print

## Student Information

Student's name _____ ( _____ ) Birthdate _____ <i>Full legal name</i> <i>nickname</i>
Grade entering _____ Gender (circle one): Male Female
Texas address _____ Texas home phone # _____
Texas guardian name: _____
Home phone: _____
Business phone: _____ Cell: _____
Spouse of Texas guardian name: _____
Business phone: _____ Cell: _____

## Emergency Contacts (**Texas numbers only**)

Adults (other than parent/guardian) to whom the student may be released:			
_____	_____	_____	_____
<i>Name</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Cell phone</i>
_____	_____	_____	_____
<i>Name</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Cell phone</i>
_____	_____	_____	_____
<i>Name</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Cell phone</i>

## Allergies (please specify)

Medications: _____
Foods: _____
Other: _____

## Tylenol/Benadryl

My child may have the following medications as needed, administered by school personnel during school hours:			
Tylenol:	Yes	No	<i>(Note: Benadryl will be administered for allergic reactions <b>only</b>; it will NOT be given as treatment of colds or stuffy nose.)</i>
Benadryl:	Yes	No	

**Respiratory Problems** (Please explain current treatment/medications)

Asthma: \_\_\_\_\_ Reactive Airway Disease: \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Will your child be carrying an inhaler? Yes No  
*(If Yes, a signed Physician's Request for Self-administration of Medication by Student MUST be on file.)*  
 Will an inhaler be available in the First Aid Station or Secondary School reception counter? Yes No

**Medical History**

Check any of the following conditions your child has or has had and explain in detail below any current or long-term **TREATMENT/MEDICATIONS/EDUCATIONAL ADJUSTMENTS**:

<input type="checkbox"/> Blood disorder (anemia, etc.)	<input type="checkbox"/> Ear problem (deafness, mastoiditis, etc.)	<input type="checkbox"/> Endocrine disorder (diabetes, hypoglycemia, etc.)
<input type="checkbox"/> Emotional problems (depression, anxiety, etc.)	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Seizure disorder (epilepsy, etc.)	<input type="checkbox"/> Kidney stones or disease	<input type="checkbox"/> HIV or AIDS
<input type="checkbox"/> Learning difference (ADD, etc.)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart problems
	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Rheumatic fever
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Vertigo/fainting spells
		<input type="checkbox"/> Sinus problems

EXPLANATION: \_\_\_\_\_  
 \_\_\_\_\_  
*(If additional space is needed, please attach a separate sheet to this form.)*  
 Any limitations/activities your child should not engage in? Please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 Any long-term medications to be administered at school? Yes No  
 (If Yes, a signed Physician's Request for Administration of Medication by School Personnel **MUST** be on file.)  
 List all long-term medications your child currently takes, with dosage amount and medical condition involved: \_\_\_\_\_  
 Any social or family situations/problems of which the school should be aware? \_\_\_\_\_  
 \_\_\_\_\_

**I hereby certify that to the best of my knowledge the information supplied herein concerning my child's physical and emotional health is accurate and complete, and I agree to keep PCA apprised of any changes to this information that may occur during the course of this school year.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
*Parent or Legal Guardian*