CHIST
CHIYODA INTERNATIONAL SCHOOL TOKYO

*CHIST:

Student Health Form

Student Information

Student's Name (Passport name) Musashino (Family) Hanna (First) (Middle)

Date of Birth Apri (month) / 2 (day) / 2011 (year) Male_____ Female ✓ Current Grade K3

Emergency Contact Information

1. Emergency Contact Person: Name Taro Musashino Relationship to Student Father
Home Phone 03-1234-5678 Work 03-1111-2222 Mobile 090-1234-5678
2. Emergency Contact Person: Name Caroline Musashino Relationship to Student Mother
Home Phone 03-1234-5678 Work _____ Mobile 090-1111-2222

Medical History

1. Does the student have any current medical conditions? Please complete the table with a check (✓). Attach additional pages if required.

☐ ADD/ADHD	☑ Asthma	☐ Diabetes	☐ Major Surgery/Accidents
☑ Allergies	☐ Congenital Anomalies	☐ Heart Disease	☐ Other _____

If yes, please provide details of your condition(s).
She is allergic to eggs and nuts. She also has asthma.

2. Is the student currently taking any medication? Yes/No
If yes, please list the student's current medication(s).

3. Does the student have any problems with hearing or vision? Yes/No
If yes, please provide details.

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4. Does the student have any health problems that restrict his or her participation in physical education, music, or any other school activities? (Yes) / No
If yes, please provide details.
When she is having asthma. she has to avoid any physical exercise such as PE.

5. Indicate with a check (✓) if you have had the following.
☑ Chickenpox ☑ Mumps ☐ Rubella (German Measles)
☐ Measles ☐ Pertussis (Whooping cough) ☐ Tuberculosis

6. Immunization Record: Please supply the dates (mm/dd/yy) of each immunization you have received. You may attach a copy of an official immunization record.

DPT-Diphtheria/Pertussis/Tetanus	1. 5 / 15 / 2011	2. 5 / 30 / 2014	3. 5 / 7 / 2016	4. ___/___/___
Polio	1. ___/___/___	2. ___/___/___		
MR (Measles/Rubella)	1. ___/___/___	2. ___/___/___		
DT-Diphtheria/Tetanus Age 12	1. ___/___/___			
Rubella	1. ___/___/___			
Measles	1. ___/___/___			
BCG	1. ___/___/___			

Any additional vaccinations:

7. Medical Permission
I hereby give permission for my child to be given temporary medication by the school nurse. Medication used in the nurse's office may include, but is not limited to paracetamol, acetaminophen and ibuprofen.
☑ Yes ☐ No

8. Accident Treatment Permission
Understanding that my child may need emergency medical treatment during school hours or at school related activities, I give CHIST personnel permission to seek such treatment for my child as they see fit; and I expect to be contacted and consulted as soon as possible in the event of such an emergency.
☑ Yes ☐ No

I certify that all information above is correct and complete.

T.M March 1, 2018

Signature of Parent/Guardian Date