www.tcis.or.kr

# TAEJON CHRISTIAN INTERNATIONAL SCHOOL

# HEALTH FORM

RECENT PHOTOGRAPH
3.5 cm x 4.5 cm

| **Student Name (Last, First)** | **Date of Birth (mm/dd/yr)** | **Male (   )  Female (   )**<br>**Day (   )  Dorm (   )** | **Entering Grade**<br>**K1 K2 1 2 3 4 5 6 7 8 9 10 11 12** |
|---|---|---|---|
| **Father / Legal Guardian Name** | | **Office Phone** | **Cell Phone** |
| **Mother / Legal Guardian Name** | | **Office Phone** | **Cell Phone** |
| **Home Address** | | | **Home Phone** |
| **Emergency Contact Name** | **Relationship** | **Home Phone** | **Cell Phone** |

**Health Insurance Information**

| **Insurance Company** (e.g.: Tie Care:국민건강보험) | **Policy Holder Name** (가입자성명) | **Identification #** (관리번호) | **Group #** (증번호/사업장번호) |
|---|---|---|---|
| | | | |

**Please check all medications that the nurse has permission to give to the student:**

(   ) **Tylenol** *(pain & fever relief)*
(   ) **Tylenol Cold** *(general cold symptoms)*
(   ) **Cough Syrup** *(for cough)*
(   ) **Ibuprofen** *(pain relief & anti-inflammatory)*
(   ) **Throat Lozenges** *(sore throat relief)*
(   ) **Antacid, Pepto-bismol** *(for indigestion, nausea, diarrhea)*
(   ) **Antihistamine** *(for allergic reactions)*
(   ) **Treatment of illness**
(   ) **Emergency care**

**Parent / Guardian Signature:** ______________________________

**Date:** ______________________________

**In the event that I cannot be reached in an emergency, I give permission for my child to receive medical treatment, including transport to the most accessible hospital, as deemed necessary by school authorities.**

**Parent / Guardian Signature:** ______________________________

**Date:** ______________________________

# Health History

(To be completed and signed by parent / guardian)

**Student Name (Last, First): ___________________________ Date of Birth (mm/dd/yr): _______________ Male ( ) Female ( )**

**To the best of your knowledge, has your child had any problems with following? Please check yes or no.**

| Medical Condition | Yes | No | Comments if "Yes" | Medical problem | Yes | No | Comments if "Yes" |
|---|---|---|---|---|---|---|---|
| ADD or ADHD | | | | Hearing Loss | | | |
| Anemia | | | | Heart Disease | | | |
| Anxiety/Panic Attacks | | | | Hepatitis | | | |
| Asthma | | | | Pneumonia | | | |
| Behavioral Problems | | | | Rheumatic Fever | | | |
| Bleeding Disorder | | | | Scoliosis | | | |
| Chronic Ear Infection | | | | Seizures | | | |
| Developmental Problems | | | | Substance Abuse | | | |
| Depression | | | | Tuberculosis | | | |
| Diabetes | | | | Vision Problems | | | |
| Frequent Headaches | | | | Other | | | |

- **List any medication the student takes on a regular basis:**

- **Describe any serious illness, surgery, injuries, hospitalizations or allergies (food, medicine, insect, seasonal):**

- **Describe any other important health-related information about your child (i.e. feeding tube, hearing aid, insulin device, etc.):**

- **Has your child had any psychological testing, evaluation, or therapy? Yes ( ) No ( )**
- **If so, please explain and attach a copy of the most current evaluation:** ________________

# Immunization History

Taejon Christian International School
Phone: 82-42-620-9116
Fax: 82-42-620-9043
admission@tcis.or.kr

(This page to be verified by healthcare provider or vaccination records)

**Student Name (Last, First):** ______________________________ **Date of Birth** (mm/dd/yr): ________________ **Male ( ) Female ( )**

| Type of Vaccine | 1st Dose (mm/dd/yr) | 2nd Dose (mm/dd/yr) | 3rd Dose (mm/dd/yr) | 4th Dose (mm/dd/yr) | 5th Dose (mm/dd/yr) |
|---|---|---|---|---|---|
| **DPT/DTaP:** *Diphtheria, Tetanus, & Pertussis* (디프테리아, 파상풍, 백일해) | **2 months**<br>/ / | **4 months**<br>/ / | **6 months**<br>/ / | **15-18 months**<br>/ / | **4-6 years**<br>/ / |
| **Td/Tdap:** *Tetanus & Diphtheria (at age 11-12 yrs.)* (디프테리아, 파상풍 추가 접종: 11~12세) | **11-12 years**<br>/ / | | | | |
| **Polio** (폴리오) | **2 months**<br>/ / | **4 months**<br>/ / | **6-18 months**<br>/ / | **4-6 years**<br>/ / | |
| **MMR:** *Measles, Mumps, & Rubella* (홍역, 유행성이하선염, 풍진) | **12-15 months**<br>/ / | **4-6 years**<br>/ / | | | |
| **Hepatitis B** (B형 간염) | **#1**<br>/ / | **#2**<br>/ / | **#3**<br>/ / | | |
| **Varicella:** Chicken Pox (수두) | **12-15 months**<br>/ / | **4-6 years**<br>/ / | **Date of Varicella Disease:** | | |
| **Other or Disease History** | | | | | |

* TCIS follows the recommendations of the US Center for Disease Control for childhood immunizations. All immunizations must be up-to-date according to the CDC schedule before a child is allowed to begin school. At age 4-6 years, the following must be updated for school entry: DPT, Polio, and MMR. A Td Booster is recommended at age 11-12, and every 10 years thereafter. The health care provider verifying the above immunization history must sign below.

**Physician / Nurse Practitioner Name (Print):** ______________________________ **Signature:** ________________________ **Date:** ________________

**Name of Clinic / Hospital / Phone Number:** ______________________________________________________________ (Stamp or Seal)

# Physical Examination

(To be completed by Medical Doctor)

**Student Name (Last, First):**_____________________________ **Date of Birth (mm/dd/yr):**_________________________ **Male ( )** **Female ( )**

**Height:** _________________**cm** **Weight:** _______________**lbs/kg** **Blood Pressure:** ____________**mmHg**

**Hemoglobin:**______________________________________________ **Urinalysis:** ____________________________________________

| Examination | Normal | Abnormal | Comments about Findings | Examination | Normal | Abnormal | Comments about Findings |
|---|---|---|---|---|---|---|---|
| General Appearance | | | | Neck | | | |
| Skin | | | | Chest | | | |
| Head | | | | Heart | | | |
| Eyes | | | | Lungs | | | |
| Ears | | | | Abdomen | | | |
| Nose | | | | Bones, Joints, Muscles | | | |
| Throat | | | | Posture / Range of Motion | | | |
| Mouth/Teeth | | | | Neurological | | | |
| Estimated Developmental Level (if needed) | Cognitive Development | | | | | | |
| | Speech/Language Development | | | | | | |
| | Social/Emotional Development | | | | | | |

***TB Mantoux test or chest x-ray required every Two Years.**

**TB skin test or chest x-ray Result:**______________________________________________________ **Date Completed:**__________________________

| TB Screening (TCIS Office Use Only) | | | | | | |
|---|---|---|---|---|---|---|

**Recommendations / Restrictions:** ____________________________________________________________________________________

**Physician / Nurse practitioner Name (Print):** ___________________________ **Signature:** ________________________ **Date:** ________________

**Name of Clinic / Hospital / Phone Number:** ___________________________________________________________________ (Stamp or Seal)