39 Yeonhui-ro 22-gil, Seodaemun-gu
Seoul, Korea 03723
Tel: (82-2) 330-3203
Fax: (82-2) 333-5027
E-mail: sfsnurseoffice@seoulforeign.org

Please return this form to Health Office PRIOR TO the student's start date at SFS.

SFS NEW STUDENT HEALTH FORM

SFS requires that your child is immunized and receives a comprehensive physical examination BEFORE entering SFS. Parents SHOULD complete Part I – Health Information, and bring ALL parts of this NEW STUDENT HEALTH FORM to your child's physician. Part II – Report of Medical Exam should be completed by the PHYSICIAN. Part III – Medication Authorization is ONLY for the student who needs to take medication(s) during school hours, and should be signed by the parent and the physician. If there are any changes in phone numbers or contact details, please notify the student's Division Office so that Health Office can reach you in case of emergency. Thank you.

Part I – Health Information

1. Student and Family Information

Student's Family Name	First	Middle	Date of Birth (mm/dd/yr)	□ Male □ Female	Grade/Year

Father/Guardian's Name:	Mother/Guardian's Name:
Telephone (Home): _____ (Work): _____(Mobile): _____ E-mail:	Telephone (Home): _____ (Work): _____(Mobile): _____ E-mail:

Emergency Contact (When the school is unable to reach parents)

Primary Contact Name: Relationship: Phone:	Secondary Contact Name: Relationship: Phone:

2. Medical History

ADD/ADHD	☐ Yes / ☐ No	Hearing Problems	☐ Yes / ☐ No
Anxiety Disorder	☐ Yes / ☐ No	Heart Disorder	☐ Yes / ☐ No
Chicken Pox	☐ Yes / ☐ No	Hepatitis A/B/C	☐ Yes / ☐ No
Diabetes	☐ Yes / ☐ No	Scoliosis	☐ Yes / ☐ No
Epilepsy/Seizure Disorder	☐ Yes / ☐ No	Skin Problems	☐ Yes / ☐ No
Frequent Headaches	☐ Yes / ☐ No	Speech Difficulty	☐ Yes / ☐ No
Frequent Nosebleeds	☐ Yes / ☐ No	Vision Problems	☐ Yes / ☐ No
Gastrointestinal Disorder	☐ Yes / ☐ No	Other health concerns	☐ Yes / ☐ No

- If you have answered **YES** to any of the above or your child has any additional medical issues that we should be aware of, please explain in detail:

  _____

  _____

- Does your child have any allergies? ☐ Yes / ☐ No If YES, please answer the followings:

  Allergy to _____ Reaction(s) the student may have _____

  Treatments the student may need after exposure _____

- Does your child have asthma? ☐ Yes / ☐ No If YES, does the student use an inhaler? ☐ Yes / ☐ No

  If the student needs an inhaler, please indicate if the inhaler will ☐ remain with the student or ☐ be provided to Health Office for emergency use.

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

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3. Immunization Record

*SFS follows the U.S. CDC immunization schedule. All SFS students are required to have the following vaccines as scheduled.

*Please PRINT the exact dates (mm/dd/yr) of vaccinations received.

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	2 months	4 months	6 months	15-18 months	4-6 years
	/ /	/ /	/ /	/ /	/ /
Td/Tdap: Tetanus & Diphtheria	11-12 years				
	/ /				
Polio	2 months	4 months	6-18 months	4-6 years	
	/ /	/ /	/ /	/ /	
MMR: Measles, Mumps, & Rubella	12-15 months	4-6 years			
	/ /	/ /			
Hepatitis B	#1	#2	#3		
	/ /	/ /	/ /		
Varicella: Chicken pox OR Disease History	12-15 months	4-6 years	**Disease History**		
	/ /	/ /	/ /		

4. Medication Permission

Please check the following list of common medications which Health Office may administer to your child as needed at school.

Medication	
Acetaminophen(Tylenol) - pain and fever relief	☐ Yes / ☐ No
Ibuprofen(Advil) - pain relief and anti-inflammatory	☐ Yes / ☐ No
Tylenol cold - for general cold symptoms	☐ Yes / ☐ No
Sudafed(Non-drowsy) - for nasal/sinus congestion	☐ Yes / ☐ No
Cough Syrup - for cough	☐ Yes / ☐ No
Minol Troches(Lozenge) - sore throat relief	☐ Yes / ☐ No
Benadryl - for allergic reactions	☐ Yes / ☐ No
Pepto-bismol - for stomach indigestion, nausea, and diarrhea	☐ Yes / ☐ No

5. Parent Authorization

- I certify that all information given in this form is complete and correct.
- I give permission for emergency measures to be taken in case of accident or sudden illness during school hours.
- I give permission for Health Office to communicate, as needed, with school personnel about my child's medical condition(s).
- I acknowledge that it is my responsibility to inform Health Office of any changes in my child's health, physical condition, or medical needs.

Parent Signature:_____ Print Name:_____ Date(mm/dd/yr): ____/____/_____

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Part II – Report of Medical Examination

*This page needs to be filled out by a **PHYSICIAN**.

Student's Name: Last_____, First_____Middle_____

Date of Birth (mm/dd/yr): _____/_____/_____ Grade/Year _____

Height_____cm Weight_____kg Blood Pressure_____/_____(ONLY for students age 11 and older) Pulse_____

Vision: R _____ L _____ Both _____ Corrective Lens: ☐ Yes / ☐ No

NOTE: Please administer the following REQUIRED tests.	Date (mm/dd/yr)	Result
Tuberculosis Skin Test OR Chest X-ray OR TB blood test (IGRA) (NOTE: If TB skin test result is positive, either chest X-ray or TB blood test (IGRA) is required regardless of previous BCG vaccination.)		TB skin test: Chest X-ray: TB blood test (IGRA):
Hemoglobin (Students under 5 years of age are exempt from this test.)		
Urinalysis (Students under 3 years of age are exempt from this test.)		

	Normal	Abnormal		Normal	Abnormal
Ears/Hearing			Musculoskeletal		
Nose			Spine		
Mouth			Skin		
Throat			Neurological		
Neck			Nutritional		
Heart			Emotional/Psychological		
Lungs			Behavior		
Abdomen			Speech		

Physician's Comments:

Please list any medication the student takes on a regular basis.
NOTE: A separate medical form (Part III) is required for all medication and treatment to be administered at school.

Name of Medication	Purpose	Dose/Time

» **This student is physically able to participate in all physical education and sports activities: ☐ Yes / ☐ No**

If NO, please explain:

_____

NOTE TO THE PHYSICIAN: SFS follows the U.S. CDC immunization schedule. Please help us ensure this student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio & MMR at age 4-6 and DT/Td/Tdap at age 11-12. Immunization record is on a separate form (Part I - 3). If immunization is administered, please complete the form. Thank you.

** Please note that SFS does NOT accept a student's physical exam certified by a parent who may be a physician or medical professional.*

Physician Signature	**Date of Examination (mm/dd/yr)**
Printed Name	**Clinic Name & Phone Number**

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Part III – Medication Authorization

*This page is ONLY for the student who needs to take medication(s) during school hours.

Parents/guardians asking school staff to give medication(s) to their child must provide a written permission every school year that has been signed by the parent/guardian and the child's health care provider.

Student Name:	**Date of Birth:**	**Division:**	**Grade:**

PHYSICIAN ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL:

Medical Condition(s):		
Medication(s):		
Dose:	**Time to be given:**	**Route:**
Possible side effects:		
Start date:	**Stop date:**	**Refrigeration required?**
PHYSICIAN SIGNATURE:		**DATE:**
Clinic:	**Phone:**	**Fax:**

PLEASE NOTE: ALL AUTHORIZATIONS EXPIRE AT THE END OF THE SCHOOL YEAR.

Parent/ Guardian Authorization

- I request that the above medication(s) be given during school hours as ordered by my child's physician. I also request the medication(s) be given on the field trips, as prescribed.
- I will notify the school of any change in the medication(s). (i.e. dosage change, etc.)
- I give permission for the medications to be given by school personnel as delegated, trained, and supervised by school medical staff.
- I give permission for Health Office to communicate, as needed, with school personnel about my child's medical condition(s) and the treatment prescribed.
- I give permission to SFS to release appropriate medical information to the hospital in case of emergency.

Parent/Guardian Signature _____ **Date** _____