HEALTH AND EMERGENCY INFORMATION

This form, once completed, is to be returned to the Admissions Office.

This side to be completed by Parent

Student's Last Name: _____ First Name: _____
Date of Birth: _____ Grade: _____
Father's Full Name: _____ Mother's Full Name: _____
Address: _____ Home Phone Number: _____
Father's Business Phone: _____ Mother's Business Phone: _____
Father's Cell Phone: _____ Mother's Cell Phone: _____
Pediatrician: _____ Telephone: _____

In an emergency, if you are not available, we will call the emergency contacts you have designated on your child's student information sheet.

HEALTH HISTORY

Please indicate the presence or history of:
Heart Disease: _____ Diabetes: _____
Asthma: _____ Allergies: _____ Seizures: _____

Apart from the onset of illness, my child may occasionally experience:
(please circle)

Headache	Dizziness	Menstrual Cramps	Asthma
Rash	Hay Fever	Nausea	Nose Bleeds

Other: _____

Fears and Phobias: _____

Comments and/or suggested procedures: _____
_____

I give UNIS permission to administer First Aid to my child and/or dispense Antiseptics as well as certain medications such as: Calamine Lotion, Vaseline, Analgesic Creams (Ben Gay, Tiger Balm), Papaya Tablets, Medicated Throat Lozenges or Spray (Chloraseptic), Tylenol, Epinephrine, and Oxygen as needed.

Date: _____ Parent's Signature: _____

In the event that I am not available, I authorize UNIS to obtain Emergency Medical Care for my child.

Date: _____ Parent's Signature: _____

The above authorization will remain valid for the duration of your child's enrollment at UNIS, unless the authorization is withdrawn in writing.

United Nations International School
173-53 Croydon Road, Jamaica Estates, N.Y. 11432
Tel: 718-658-6166 Fax: 718-658-5742

This side to be completed by Physician

Student's Last Name: _____ First Name: _____
Date of Birth: _____ Grade: _____

CERTIFICATE OF IMMUNIZATION

In accordance with the codes enforced by the New York Health Department, each child enrolled in any NYC school is required to present proof of the following immunizations before attending school:

Diphtheria Series (3) m__/d__/y____ m__/d__/y__ m__/d__/y__ Booster m__/d__/y__
(required for all JA students)
Trivalent Oral-Polio (3) m__/d__/y____ m__/d__/y__ m__/d__/y__ Booster m__/d__/y__
Live Measles Vaccine m__/d__/y____ or disease ► m__/d__/y__ Booster m__/d__/y__
(required if born on or after 1 Jan. 1985)
Mumps Vaccine m__/d__/y____ or disease ► m__/d__/y__ Booster m__/d__/y__
Rubella Vaccine m__/d__/y____ or titer results ► _____ Booster m__/d__/y__

Hepatitis B Vaccine m__/d__/y____ m__/d__/y__ m__/d__/y__
(Hepatitis B Vaccine is mandatory if born on or after 1 Jan. 1993 or when entering M3, M4, T1, T2, & T3)
Varicella Vaccine m__/d__/y____
(Varicella Vaccine is mandatory if born on or after 1 Jan. 1998)

Other: _____

Date of Exam: _____

HEALTH APPRAISAL

Height: _____ Weight: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____

Vision: R_____/_____ L_____/_____ R_____/_____ L_____/_____
uncorrected *uncorrected* *corrected* *corrected*

Please indicate current status and/or history of the following:

Eyes_____ Heart_____ Neurologic_____
Ears_____ Lungs_____ Skin_____
Lymph Nodes_____ Abdomen_____ Allergy_____
Thyroid_____ Genito-Urinary_____ Hct_____
Tonsils_____ Orthopedic_____ TB-Test results_____
Teeth_____ Posture_____ Mantoux-PPD only
(Required of all new students attending NYC schools, grades 5 – 12)

Please detail any abnormal finding or history:

Does the student take medication?_____
Full physical activity at school, including swimming: Yes_____ No_____
Modified physical activity due to_____
Any activity contraindicated_____
May the student participate in competitive contact sports? Yes_____ No_____

Name of Medical Doctor_____ Address/Tel. # below (please stamp)
(Health Care Practitioner)

Signature:_____ Date:_____

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