

EMERGENCY CONTACT INFORMATION

Parent or Guardian: In order to care for your child in the event of an accident, sudden illness or other emergency, please complete all sections below and sign in the space provided. Please notify the Nurses' Office of any changes if and when they occur.

Student's Name: _____
First Name, Middle Name, Family Name

Preferred Name: _____ Sex: Male Female

Date of Birth: _____ / _____ / _____ Nationality: _____
Month Day Year

Student Resides with: Both Parents Mother Father Guardian

Mother's phone: _____ Father's phone: _____

For Emergency – Person(s) to call IF one of parents cannot be reached:

Primary Contact: _____ Secondary Contact: _____

Phone: _____ Phone: _____

Cell Phone: _____ Cell Phone: _____

Local Doctor or Health Care Provider _____

Phone: _____

If student will be staying with a guardian, please provide contact information for the parents:

Phone number: _____ E-mail: _____

Does your child have any Medical Considerations: Yes No

Kind: _____

Does your child have any Allergies: Yes No

Kind: _____

Reaction: _____

If an allergic reaction should occur, I give AISD permission to give an antihistamine to my child. Yes No

Do you give AISD permission to give medications (acetaminophen, ibuprofen, chloraseptic throat spray, and/or bismuth subsalicylate) to your child if needed? Yes No

Is your child to be given regular medication during the school day? Yes No

If yes, be sure to send permission slip and directions with the medication to the Nurses' office.

Kind: _____

Reason: _____

I give permission for my child to receive medical treatment in a medical emergency as the school deems necessary for the child's welfare. In cases of emergency or sudden illness requiring immediate care, your child will be taken to the nearest hospital and you will be notified as soon as possible.

Parent or Guardian Signature

Date

IMMUNIZATION/ HEALTH SCREENING HISTORY

Students are expected to meet the AIS/D Immunization and Tuberculosis Screening requirements upon entry or at the beginning of the school year. However, when a series of immunizations are required, such as for polio, your child will be provisionally permitted to attend school after the initial dose. AIS/D follows the Center for Disease Control Immunization Schedules. This may be different from your home country or country you are moving from.

Parent or Guardian: Please write in the dates of the required immunizations and TB screen in the table below. Use MONTH/DAY/YEAR format.

Polio

1.	2.	3.	4.
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Diphtheria/Pertussis/Tetanus (DPT)

1.	2.	3.	4.	5.
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Mumps/Measles/Rubella (MMR) (Measles alone not acceptable)

1.	2.
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Chickenpox

1.	2.	If child had Chickenpox put date here:
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Haemophilus influenza, type B (Hib) (Required only if student less than five years old)

1.	2.	3.	4.
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Hepatitis A

1.	2.
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Hepatitis B

1.	2.	3.
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TB Screening (Required every two years) If your child has had a BCG a physical exam is acceptable, otherwise a skin test or Chest X-Ray is required.

BCG date:	CXR:	Physical:	Skin Test:
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Due to the incidence of TB in Bangladesh, it is recommended that a PPD skin test be done for all students not immunized with BCG every two years.

Student immunized with BCG will need to be screened by health professional with TB questionnaire.

Does the child have any of the following:

Persistent cough: Yes No

Coughing up blood: Yes No

Persistent fever: Yes No

Excessive weight loss: Yes No

Excessive fatigue: Yes No

Has the child been in close contact with:

Someone with TB: Yes No

History of positive PPD: Yes No

IF YES to any questions, then a chest x-ray needs to be done.

Date Screened

Dr./Nurse Signature