STUDENT HEALTH AND EMERGENCY INFORMATION
School Year 2022-23

Family Name:(Last)	**Given Name:**(First)	**Male/Female:**
Birth Date:_(DD/MM/YY)_	**Common Name Used in School:**	**Grade:**

Does your student have or ever had any of the following medical conditions:
Check (✔) the ones that apply:

	ADD/ADHD, Autism, Aspergers	**Headaches**	
	Anxiety / Panic Attack	**Heart Condition**	
	Asthma	**Hearing Problem**	
	Cerebral Palsy	**Seizures**	
	Color Blindness	**Skin Problems**	
	Diabetes	**Wears glasses or corrective lenses**	
	Digestive Problems	**Other:**	
	Emotional Concern	**None of the above**	

If you checked a medical condition, **please explain** more in detail:

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PE ACTIVITY: Children are expected to participate fully in physical education and swimming class. If your child requires limited PE class, please explain:

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______________________________ Check (✔) box if **No Limitations** ☐

OVER-THE-COUNTER PAIN MEDICATION: In the event your child needs a one-time pain medication while at school (i.e., menstrual cramps), you would like the school nurse to:

Give 500mg of Tylenol ☐ Give 200mg of Ibuprofen ☐

Give 250 mg of Tylenol ☐ Give 400mg of Ibuprofen ☐

Other ____________ ☐ Call parents/guardians first ☐

ROUTINE MEDICATIONS (Include inhalers, prescription, over-the-counter, and herbal) Check (✔) box if **None** ☐

Medication Name	Dose	Frequency	Purpose
1.			
2.			
3.			

ALLERGIES Check (✔) box if **None** ☐

Food allergy:	Reaction:	Treatment:
Medication allergy:	Reaction:	Treatment:
Other allergies:	Reaction:	Treatment:

EMERGENCY CONTACT INFORMATION Please give contact information of both parents/legal guardians

Parent/Guardian Name	**Relationship**	**Email address**	**Phone Number**
1			
2			

PLEASE PROVIDE TWO OTHER EMERGENCY CONTACT NUMBERS IF WE ARE UNABLE TO CONTACT A PARENT:

Emergency Contact Name	**Relationship**	**Phone Number**
1		
2.		

CONCERNING MEDICAL TREATMENT AT LOGOS INTERNATIONAL SCHOOL:

1). All **medication** administered at school must be given by the school nurse and only with parental consent. In order to administer medication brought from home, a **Logos Medication Authorization Form** from the office must be filled out. Also, all medication must be clearly labeled with the medication name, dosage, and remain in original packaging.

2). As parents/guardians, **if you are out of the city/country,** it is important to inform the school office of a temporary guardian for your child(ren) along with their phone number in case of an emergency.

3). In the event of a **life-threatening emergency**, the student will be transported to Royal Phnom Penh Hospital by a school van along with two Logos staff. If there is suspicion of a spinal injury, an ambulance will transport the student to Royal Phnom Penh Hospital.

When signing this form you are saying that you acknowledge the above information and that all information you give on this form is correct. Also, in the event, your child has a medical emergency during school hours, and a Logos Staff member is unable to contact a parent and/or guardian, by signing this form you give permission for a physician, nurse, dentist, hospital, and/or paramedic to administer any necessary life saving medical treatment/medication.

Parent/Guardian Signature: ____________________________________ **Date:** ______________________

(DD/MM/YY)

Relationship to child: ____

PLEASE ATTACH A COPY OF ANY NEW UPDATES TO YOUR CHILD'S IMMUNIZATION RECORD ON FILE