



New School International School of Georgia

Medical Record

Child's Name

Family Name

Illness (Please mark the relevant box if your child has had any of the following, stating the date)

Chicken Pox	Date:	Whooping cough	Date:
German measles	Date:	Mumps	Date:
7-day Measles	Date:	Rheumatic Fever	Date:
Scarlet Fever	Date:	Tuberculosis	Date:
Pneumonia	Date:	Poliomyelitis	Date:
Frequent headache			Date:

Please mark the relevant box if your child has any history of the following:

Allergies	Asthma	Diabetes Type
Epilepsy/convulsions	Fainting	High/Low blood pressure
Menstrual problems	Skin problems	Ear infection
Congenital abnormalities	Operation	Hearing difficulty
Behavior Problems	Serious Injuries	Speech difficulty
Frequent headache	Eating problems	Vision difficulty
Migraine	Orthopedic Problems	Frequent nose bleeding
Heart problems		
Other or explanation		

Please explain all categories marked "Yes" in detail on separate sheet

Is your child currently psychologically or physically incapacitated in any way or under medical supervision? Yes No

If yes, please give details:

Is your child now under medical care or taking medication? Yes No

If yes, please give details:

Is there any restriction on physical activity? Yes No

If yes, please give details:

Immunization (Please fill in the chart and enclose copy of immunization record)

	Tick here	Date: (M/Y)	Date: (M/Y)	Date: (M/Y)
Polio Oral				
Polio Injected				
Diphtheria				
Whooping Cough				
Tetanus Booster				
Measles				
Mumps				
Rubella				
BCG				
Hepatitis A				
Hepatitis B				
DPT				
FSME Tick Borne E				
Last TB Test			Results:	

I accept full responsibility for providing adequate health insurance for my child at all times and acknowledge that it is not the New School, International School of Georgia's responsibility to provide such insurance

Parent/Guardian signature and name

Date