Cebu International School

Pit-os, Cebu City 6000, Philippines
Telephone Number: +63 32 888 1111
www.cis.edu.ph

Health Registration & Authorization Form

The information on this form will be treated confidentially, and only shared with school personnel on a need-to-know basis. Page 1 & 2 of this form must be filled out completely by parents (in print) and Page 3 must be completed by a licensed physician.

To be completed by a parent or guardian:

Student's Name (Last, First, Middle)	**Birth Date** (MM/DD/YYYY)	**Sex**	**Grade Level**	**School Year**
		☐ Male ☐ Female		

Name of Parent/Guardian (Last, First, MI)	**Mobile No.**	**Landline No.**
Father:		
Mother:		
Emergency contact/s, other than parents (Last, First, MI)	**Mobile No.**	**Landline No.**

Doctor's Name:		**Contact Numbers:**
Dentist's Name:		

PAST OR PRESENT MEDICAL HISTORY

Does your child have a past or present history of the following? (**Y**-Yes / **N**-No)

ADD / ADHD	☐ **Y** ☐ **N**	Seizure Disorder	☐ **Y** ☐ **N**	Heart Disorder	☐ **Y** ☐ **N**	Skin Problems	☐ **Y** ☐ **N**
Anxiety Disorder	☐ **Y** ☐ **N**	Frequent Headaches	☐ **Y** ☐ **N**	Rheumatic Fever	☐ **Y** ☐ **N**	Speech Disorders (stuttering, slurring, lisp)	☐ **Y** ☐ **N**
Chicken Pox	☐ **Y** ☐ **N**	Frequent Nosebleeds	☐ **Y** ☐ **N**	Pneumonia	☐ **Y** ☐ **N**	Vision Problems	☐ **Y** ☐ **N**
German Measles	☐ **Y** ☐ **N**	Gastrointestinal Disorder	☐ **Y** ☐ **N**	Tuberculosis	☐ **Y** ☐ **N**	Dyslexia	☐ **Y** ☐ **N**
Mumps	☐ **Y** ☐ **N**	Diabetes	☐ **Y** ☐ **N**	Scoliosis/Lordosis	☐ **Y** ☐ **N**	Hearing Disorder (deafness, conductive hearing loss, others)	☐ **Y** ☐ **N**
Polio	☐ **Y** ☐ **N**	Hepatitis A/B/C	☐ **Y** ☐ **N**	COVID-19	☐ **Y** ☐ **N**	Hand Foot & Mouth Disease (HFMD)	☐ **Y** ☐ **N**

If you have checked **YES** on any of the above medical history/condition**,** please provide more information & any medical or supporting documents available:

Does your child have any allergies: ☐ **Y** ☐ **N.** If **YES,** please check below allergens that your child is affected by:

Peanuts		Fish		Crustaceans (shrimp, crabs, prawns)		Shellfish (oysters, squid, octopus)	
Poultry (chicken, egg, duck)		Tree nuts (walnut, almonds..)		Soy		Dairy (milk, cheese, others)	
Gluten		Wheat		Other:			

Does your child have asthma? ☐ **Y** ☐ **N** — If **YES**, does the student need an inhaler? ☐ **Y** ☐ **N**

If the student needs an inhaler, please indicate if the inhaler will:	remain with the student, or		be left in the clinic for emergency use	

If your child has any other significant health conditions that may require emergency medical care at school, field trips or sports activities, please provide more information below:

Additional Information Required:

Contact lens	□ Y □ N	Use of a wheelchair / crutches	□ Y □ N	Hospitalization in the last 3 years	□ Y □ N
Eyeglasses	□ Y □ N	Orthodontics (braces, retainers)	□ Y □ N	Reason for hospitalization:	
Hearing aid	□ Y □ N	Orthopedic Braces (scoliosis, lordosis)	□ Y □ N		

(For female students only) **At what age did your daughter's menstrual cycle begin?**

IMMUNIZATION RECORD (Dates: MM/DD/YYYY)

Besides filling out the form below for reference, a photocopy of the child's immunization record is requested for reference. * Required

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
* BCG (for tuberculosis)						
* DPT (Diphtheria, Pertussis & Tetanus)						
* OPV (Oral Polio Vaccine)						
* Hepatitis B						
* Measles						
* MMR (Measles, Mumps, Rubella)						
* Varicella						
Hepatitis A						
HPV (Human Papilloma Virus)						
PCV (Pneumococcal Conjugate Vaccine/Flu Vaccine)						
RV (Rotavirus)						
COVID-19 – please specify vaccine:						

AUTHORIZATION

I give consent for my child to receive the following from the school clinic:

Minor first aid	□ Y □ N	Minor emergency care	□ Y □ N	Oral non-prescription medication	□ Y □ N

I hereby authorize the CIS school nurse to administer the following medications (please check):

Description & Type of Medication	Brand / Dosage	Y	N	Description & Type of Medication	Brand / Dosage	Y	N
Analgesic / Pain reliever-Paracetamol	Biogesic Tab. 500 mg			Muscle Pain Reliever – Ibuprofen, Paracetamol	Alaxan		
Antipyretic / Fever relief - Paracetamol	Tempra / Calpol Syrup 120mg/5ml			Antipruritic/Anti-itch – Calamine, Diphenhydramine	Caladryl Lotion		
Mefenamic Acid / Pain relief	Ponstan Tab 250mg			Minor Skin Irritation – Menthol & Zinc Oxide	Calmoseptine 555.7mg/164.5mg (5g)		
Cough / Cold Remedy – Paracetamol, Phenylpropanolamine HCl	Decolgen Tab 25mg/500mg			Anti-burn / Anti-bacterial – Silver Sulfadiazine	Flammazine Cream		
Nasal Decongestant – Paracetamol, Phenylpropanolamine HCl	Neozep Tablet			Mupirocin – topical antibacterial	Bactroban / Foskina		
Antacid – Magnesium Hydroxide, Aluminum Hydrochloride	Kremil-S Tablet			Anti-diarrhea - Loperamide	Imodium		
Mouth/Throat Preparations – Dichlorobenzyl alcohol, amylmethacresol	Strepsil Lozenges			Mouth/Throat Preparations – Hexetidine	Bactidol (gargle)		
Cold/allergy/antihistamine - Cetirizine	Virlix 10 mg						

________________________ Parents' Name

________________________ Parents' Signature

______________ Date

<table>
<tr><td colspan="6">PHYSICAL EXAMINATION. To be completed by a Licensed Physician. This form is mandatory for school admission and must be completed no more than 12 months before the expected start date.</td></tr>
<tr><td>Height (cm)</td><td></td><td>Blood Pressure (optional)</td><td></td><td rowspan="2">Vision</td><td>Left -</td></tr>
<tr><td>Weight (kg)</td><td></td><td>Blood Type (optional)</td><td></td><td>Right -</td></tr>
</table>

Please review the following areas:	**Normal**	**Findings**	**Description** (attach additional sheets if necessary)
Head, Eyes, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Mammary			
Summary of Findings & Comments:			

Physician's Summary & Recommendations: This is to certify that ____

(Complete Name of Child Examined)

is physically fit to participate in Physical Education activities that are required in the curriculum, including extracurricular activities that are part of the school program.

____ ____________________ ______________________________________

Physician's Signature Over Printed Name / License Number Date Examined Contact Number & Email Address