KINABALU INTERNATIONAL SCHOOL
NURTURING GLOBAL CITIZENS

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Please complete all sections of the form in block letters or typed. Please notify the school office immediately of any changes to your child's medical conditions or your emergency contact details.

Student Health Assessment Record

STUDENT INFORMATION

Student's Name					
Birthdate (D/M/Y)	Age	Sex (M/F)	Nationality	Religion	Class
Address:			Blood group:		
Parent/Guardian Name: 1)			Mobile telephone:		
2)			Mobile telephone:		
Emergency Contact Name (if parents cannot be reached):			Relationship to child:	Mobile telephone:	
Doctor's Name:			Doctor's telephone:		
Health Insurance Details (Company, Policy number and Contact Information):					

STUDENT MEDICAL HISTORY

(a) Has your child been diagnosed with any of the following?

	Yes	No	Comments
Allergies:			
1)Medication (e.g. Iodine)			
2)Food (e.g. eggs, peanut's, seafood			
3) Others (e.g. plaster)			
Asthma			
G6PD			
Chicken pox			
Epilepsy/ Seizures			
Diabetes			
Measles			
Rubella			
Mumps			
Pertussis			
Poliomyelitis			
Hepatitis A,B and C			

Tuberculosis			
ADD/ADHD			
Heart Problems			
Meningitis			
Chronic ear infection			
Urinary tract infection			
Eczema			

(b) Has your child ever had any surgery/hospitalisation in the past? ☐ Yes ☐ No

If yes, please give details_____

_____

_____

(c) Any other relevant information regarding your child's medical history?

Vision screening *(can be done by own doctor or school nurse)*

	Left	Right
Score	20/	20/
Was test performed with corrective lenses?	Yes ☐	☐ NO

IMMUNISATION RECORD

Below is the list of vaccinations required by the Ministry of health Malaysia

(d) Please record the date of each dose received (dd/mm/yyyy)

Vaccine	Date	Clinic/Hospital
BCG (Bacille Calmette-Guerin)-tuberculosis Dose 1 (Newborn)		
Hepatitis A Dose 1 (12 mth and older)		
Hepatitis B Dose 1 (Newborn) Dose 2 (1st month) Dose 3 (6th month)		
DTaP-diphtheria, tetanus and Pertussis (whooping cough) Dose 1 (2nd ,month) Dose2 (3rd Month)		
Dose 3(5th month) Booster Dose (18th months)		

Hib-Haemophilus influenza Type B Dose 1 (2nd month) Dose 2 (3rd month) Dose 3 (5th month) Booster Dose (18th months)		
Polio (IPV) Dose 1 (2nd month) Dose 2 (3rd month) Dose 3 (5th month) Booster Dose (18th months)		
Measles (Sabah Only) Dose 1 (6th month)		
MMR-measles, mumps and rubella Dose 1 (9th months) Dose 2 (1 year)		
MMR-measles and rubella Booster dose (7years)		
DT-diphtheria and tetanus toxoids Booster dose (7years)		
HPV-Human papillomavirus Dose 1 (13 years)		
ATT-tetanus toxoid Booster dose (15years)		
Covid-19 Dose 1 Dose 2 Booster dose		
Additional Vaccinations received		

EMERGENCY CARE PERMISSION

Permission is hereby given for emergency measures to be taken in case of accident or sudden illness with the understanding that I will be notified as soon as possible.

I wish to be informed of every medication given to my child. ☐ Yes ☐ No

Staff may use their discretion regarding medication given to my child. ☐ Yes ☐ No

I certify that all information given on this form is complete and correct.

I acknowledge that it is my responsibility to inform the school nurse of any changes in my child's health, physical condition or medical needs.

_____ _____

SIGNATURE OF PARENT/ GUARDIAN DATE

PRINT NAME: _____

Revised: 05/09/2023