Please read and complete this form <u>carefully</u> in order to assist The International Independent Schools in providing proper assistance in case of illness at school.

Name of Student:		
(FIRST)	(FATHER) (FAMILY)	
Please tick ($$) all applicable health issues:		
Bronchial Asthma	Skin diseases	
Allergic reaction to medication	Diabetes	
Bee-sting allergy	Epistaxis (nose bleeding)	
Food allergies	Thyroid problems Scoliosis	
Convulsions or epilepsy Fainting spells	Urinary system problems	
Phobias	Digestive system problems	
Tuberculosis	Eczema	
Heart diseases	Severe or frequent headaches	
Vision problems	Past history of surgery	
Hearing problems	Other	
If you ticked any of the above, please provide details:		
Is your child required to take regular medication? If so, gi	ve details (name, dosage and reasons): Yes 🗌 No 🗌	
Is there any reason why your child cannot participate in t If yes, please state reasons:	he full Physical Education program? Yes 🗌 No 🗌	
Is there anything else about your child's medical history performance or ability to undertake school programs?	that the school needs to know about and that might aff Yes 🔲 No 🔲	fect his/her a cademic
Do you have any objection to the school doctor examinin	ig your child? Yes 🗌 No 🗍	
Does your child wear glasses?	Yes 🔲 No 🗖	
Is there a history of color blindness in your family?	Yes 🔲 No 🗖	
Does your child have difficulty in hearing?	Yes 🔲 No 🗖	
Has your child been hospitalized? If yes, when and for wh	at? Yes 🗌 No 🗍	

The Ministry of Education in Jordan requires that the school maintain current information on each child's immunization history. It is therefore important that the International Independent School have a copy of your child's immunization records. (*Please tick the appropriate box*):

Emergency Contacts (Parents/ Guardians)					
Name & Relationship	Mobile No.	Home No.	Work No.		
1.					
2.					
Alternative Emergency Contacts (Other than Parents)					

Alternative Enlegency Contacts (Other than 1 arents)						
Name & Relationship	Mobile No.	Home No.	Work No.			
1.						
2.						

If the above contact numbers cannot be reach	ed, I g	gi <u>ve</u> the	e Internatio	onal Independent	Schools	/ Medical	staff	permission	to seek
appropriate emergency treatment for my child.	Yes		No 🗌						

I hereby give my permission for the International Independent Schools to:	
Give my child non-prescription medication if needed.	
Administer First Aid to my child if needed.	
Admit my child to a hospital in case of an extreme emergency.	
Conduct regular medical checks including hearing, vision and checks for skin infections and pediculosis.	

Parent/ guardian's Name: _____

Parent/ guardian's signature: _____

Date: _____

Note:

If your child is taking a prescribed medicine and has to take it during school hours, please bring the medicine to the school's nurse first thing in the morning. It can then be collected from the nurse before going home.

Please clearly write your child's name, class and medication intake time.