** SAINT PAUL AMERICAN SCHOOL**

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| **MEDICAL INFORMATION AND****INOCULATION RECORD****To be completed, signed and dated by a physician.** |

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle

The student must have a physical examination by a licensed physician, who is not a family member,

**within the 6 months preceding school enrollment**. The physician should complete this report on the

applicant’s medical history, current health and immunization.

**PART I - MEDICAL HISTORY**

Has the applicant ever had a history of any of the following:

Yes No Yes No Yes No Yes No

Allergies Eating disorder Measles Polio

Appendicitis Enuresis Mumps Scarlet Fever

Appendix removal Headache Menstrual disorder Seizure disorder

Asthma Hepatitis Parasites Sleep disorder

Chicken pox Goiter Pneumonia Tonsils Removal

Cough (persistent) Hernia Rheumatic fever Tuberculosis

Diabetes Mellitus Malaria Rubella; Year:\_\_\_\_\_\_\_ Vertigo

Any disease, impairment or abnormality of:

Yes No Yes No Yes No Yes No

Digestive system Ears, Hearing Locomotor system Varicose veins

Bones, joints Genito-Urinary Lungs Tonsils, throat

 Brain, Nervous system Menstrual cycle nose

system Heart, Blood Skin (acne, etc.) Immune System

Blood, Endocrine vessels

system

Has the applicant had any of the following:

Yes No Yes No Yes No

restriction of a physical treatment or counseling for a difficulty with school

activity during the last nervous condition, personality, studies or teacher

five years character disorder or emotional

problems

Please give a detailed explanation of any of the items above marked “yes.” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the applicant ever been hospitalized: Yes No If “yes,” please give the date and diagnosis of

each illness or accident.

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Is the applicant taking any medication at this time? Yes No If “yes,” please list medication(s) and reason(s). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION AND INOCULATION RECORD**

(continued)

**PART II - PHYSICAL EXAMINATION OF STUDENT**

Height\_\_\_\_\_\_\_\_(m) Weight\_\_\_\_\_\_\_\_(kg) Blood Pressure\_\_\_\_\_\_\_\_\_\_\_

Does the student wear contact lenses? Yes No Does the student wear glasses? Yes No

Applicant’s uncorrected vision: R \_\_\_\_ /\_\_\_\_ L \_\_\_\_ /\_\_\_\_ With correction: R \_\_\_\_ /\_\_\_\_ L \_\_\_\_ /\_\_\_\_\_

Hearing: R \_\_\_\_\_\_ /\_\_\_\_\_\_ L \_\_\_\_\_\_ /\_\_\_\_\_\_ With correction: R \_\_\_\_\_\_ /\_\_\_\_\_\_ L \_\_\_\_\_\_ /\_\_\_\_\_\_

Are there any current abnormalities of the following systems? If “yes” provide additional information.

Yes No Yes No Yes No

Cardiovascular system Menstrual Cycle Respiratory System

Ears, Nose, Throat Musculoskeletal Skin (acne, etc.)

Eyes Metabolic/Endocrine Teeth and Gums

Gastrointestinal Neuropsychiatric Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genito-Urinary System Pelvic

Is the student now under treatment for any medical or emotional conditions? Yes No

If “yes,” please explain:

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Does the student have an eating disorder or a history of eating disorder? Yes No

If “yes,” please explain:

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Recommendation for physical activity: Unlimited Limited (please explain)

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Your opinion on the student’s state of health: Excellent Good Fair Poor

Physician’s Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION AND INOCULATION RECORD**

(continued)

**PART III - Immunization Record**

According to Minnesota State Law, all students must receive certain immunizations in order to be

enrolled in school. Therefore, a student will not be enrolled in classes at Saint American School

unless he/she has received all of the required vaccinations.

**Instructions:**

1. This form must be completed by a physician.

2. For each vaccination/test, the month, day, and year must be recorded. Attach additional documentation as necessary.

3. If the student has had the disease, the date and treatment should be recorded in the appropriate column.

4. Carefully review the guidelines for each inoculation to determine if the student has received the required number of doses.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Type of Vaccine** | **1st Dose****Mo/Day/Yr** | **2nd Dose****Mo/Day/Yr** | **3rd Dose****Mo/Day/Yr** | **4th Dose****Mo/Day/Yr** | **5th Dose****Mo/Day/Yr** | **History of Disease****Date/Treatment** |
| **Polio** |  |  |  |  |  |  |
| ***Requirement:*** *at least 3 doses.* |
| Diphtheria, Tetanus, and Pertussis (DTaP, DTP) |  |  |  |  |  |  |
| Tetanus Diphtheria (Td) |  |  |  |  |  |  |
| Pertussis |  |  |  |  |  |  |
| ***Requirement:*** *At least 3 DTP doses AND one Td shot at age 11 or older. However, If a Td was given after the 7th birthday, it must be**repeated 10 years after the last dose. Note: If student has not been vaccinated for Pertussis, he/she does not need to be (children age 7 and**older are not given this vaccine).* |
| Measles, Mumps, Rubella (MMR) |  |  |  |  |  |  |
| ***Requirement:*** *2 doses, both given after 12 months of age.* ***If the first dose was administered prior to the student’s first birthday, a third******dose is required.*** |
| Hepatitis B (Hep B) |  |  |  |  |  |  |
| ***Requirement:*** *3 doses. A 3rd dose is not required if documentation of the alternative 2-dose schedule is provided.* |
| Varicella (Chickenpox) |  |  |  |  |  |  |
| *This immunization is not required, but is recommended for students who have not had chickenpox disease. Please indicate history of this**disease above.* |
| Bacillus Calmette-Guerin |  |  |  |  |  |  |
| *This is not a required nor recommended vaccination.* |
| Other: |  |  |  |  |  |  |
|  |
| TB Skin Test (Mantoux) | Date Given (Mo/Day/Yr): | Time Given: | Date Read (Mo/Day/Yr): | Time Read: |
| Results: \_\_\_\_\_\_\_\_\_\_mm \_\_\_\_ positive \_\_\_\_ negative |
| Chest X-ray | Date Given (Mo/Day/Yr): | Results/Treatment: |
| ***Requirement: Student must have a TB test within 6 months prior to arrival in the U.S. If TB Skin Test is positive, the student must******have a chest x-ray and submit the results to the school.*** |

**MEDICAL CARE RELEASE / LIABILITY RELEASE**

*To be read, signed and dated by the student*

*and both parents or legal guardians.*

In case of illness, accident or injury, we grant permission to examine and treat our child, whose signature appears below, at an appropriate medical facility and to make referrals to outside physicians and facilities as indicated. We grant permission to release information regarding our child’s health to any individuals designated by Saint Paul American School, its Overseas Partners or its representatives. We also grant permission for our child to receive any and all immunization(s) required for participation in an academic program. We understand that we must pay for any necessary immunization(s).

While under the sponsorship of the Saint Paul American School Program, the student may not participate in skydiving, hang gliding, glider riding, parachute jumping, para-sailing, jet skiing, hot air ballooning, scuba diving, mountaineering, bungee jumping, and/or any activity that Saint Paul American School or its Overseas Partners defines as a high-risk activity. We also understand that our child may not drive any motorized vehicle during his/her exchange experience.

In anticipation of my son’s/daughter’s (child’s) acceptance to participate in the Saint Paul American School academic program, we, the undersigned (student and parents/legal guardians) hereby release Nacel International School System, its Overseas Partners, its Board of Directors, Agents, Community Coordinators from any and all current and future claims, charges, costs and/or causes of action for loss of property, personal injury, illness, accident or death sustained by my child during the time that he/she is a participant in the program, whether covered by current insurance or not. I further agree to indemnify and hold harmless all of the above named from any and all liabilities, including liabilities to third parties, which may arise from my child’s participation in the program, including all activities specified herein, in the Standards of Conduct, and elsewhere.

We, the undersigned, grant Saint Paul American School permission to use photographs and any other materials, in which the participant may appear, for promotion or publicity of future programs.

We, the student and parents, certify that all information provided in the application is correct and complete, including medical and inoculation history. We understand that withholding information and/or providing incorrect information is grounds for possible termination from the program and repatriation at the parents’ expense with no refund of program fees.

This agreement covers the period from the time our child enters to the Philippines, until the student departs from it.

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Signature of the father/legal guardian Print father’s/legal guardian’s full name Date

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Signature of the mother/legal guardian Print mother’s/legal guardian’s full name Date

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Signature of student Print student’s full name Date