



INTERNATIONAL SCHOOL OF HAVANA MEDICAL CARD

STUDENT INFORMATION

Name: _____

Age: _____ Date of Birth: ____ / ____ / ____ Home telephone: _____
Day Month Year

Address: _____

PARENTS INFORMATION

(Please write in BLOCK letters)

Mother's full name: _____

Father's full name: _____

IN CASE OF EMERGENCY

Person in charge: _____

Home telephone: _____ Cellular phone: _____

Office telephone: _____

Name of Physician/Doctor: _____

Telephone: _____ Beeper: _____

In an emergency when the parents cannot be contacted, who should we notify? Please include the person's telephone number.

In case of emergency, and in case the parents cannot be contacted, what hospital should we take your son/daughter to?

Please sign to indicate that you authorize the school to act in an emergency if you cannot be contacted

In what hospital do you have your medical insurance coverage?

HAS YOUR CHILD HAD OR IS CURRENTLY SUFFERING FROM ANY ILLNESSES?

Please check the corresponding box

CHICKENPOX () HEPATITIS () MEASLES () MUMPS () BRONCHIAL ASTHMA () CONVULSIVE SYNDROME () EPISTAXIS (Frequent nose bleeding) ()

SURGERIES () Specify _____ OTHER () Specify _____

PLEASE CHECK THE CORRESPONDING BOX

ALLERGIES: to MEDICATION () to INSECT BITES () to FOOD ()

OTHER () Specify the type of allergy: _____

IS YOUR CHILD ON SPECIAL MEDICATION: YES () NO ()

Specify the type of medication being taken and why: _____

PHYSICAL EXAM – TO BE FILLED OUT BY THE DOCTOR

WEIGHT _____ HEIGHT _____ BLOOD GROUP _____

NEUROLOGICAL EXAM _____ EYE SIGHT _____

OTHER CONDITIONS: _____

VACCINATION HISTORY (PLEASE RECORD THE DATE OF LAST VACCINATION)

DPT _____ POLIO _____

MEASLES _____ FLU (INFLUENZA) _____

HEPATITIS _____ M.M.R. (Measles, Mumps, Rubella) _____

CHICKENPOX _____ CHOLERA _____

OTHER: _____

NAME OF DOCTOR _____

SIGNATURE AND STAMP _____

DATE: _____ PARENTS / GUARDIANS SIGNATURE: _____

OFFICE USE ONLY

COMPLETE

NOTEWORTHY
CONDITIONS

IMPORTANT
CONDITIONS