



THE AMERICAN INTERNATIONAL SCHOOL OF MUSCAT
ANNUAL STUDENT HEALTH FORM 2018 - 2019

Parents: To ensure that our records are current, both sides of this form must be completed each year by the parent or guardian. Please make certain that the school is promptly informed of any changes, especially telephone numbers.

A student may not be allowed to participate in after school activities or field trips if this form is not submitted annually.

Name: _____

Grade: _____

Birth date: _____
(Month/Day/Year)

Male/ Female _____

Current Allergies and Treatment on record:

Current Medical Considerations on record:

Any changes to above? YES NO If YES, complete the box below, if NO, continue to Authorizations.

New Medical Information

Recent illness(es): _____

Current medications and dosage: _____

List new allergies: _____ Reaction: _____

What medication do you normally use if your child has an allergic reaction? _____
(Please provide the School Nurse with the medication you would use, to have on hand for emergencies.)

Any adverse reactions to any medications? _____

List any physical aids used: _____
(glasses, contact lenses, hearing aids, etc.)

Significant Physical or Medical conditions: _____

Other comments that would assist us (recent family illness/death, divorce, marriage, etc.) _____

Authorizations

I give permission for TAISM staff to administer over-the-counter medications such as throat lozenges, Panadol (Tylenol), or Ibuprofen.

YES / NO
(please circle one)

I understand that in the event of a medical event or emergency, the school will administer immediate first-aid needs, and will contact the parent/guardian as soon as possible.

YES / NO
(please circle one)

In the event of an emergency, I give permission for TAISM staff to admit my child to a hospital of the school's choice, or contact a doctor as deemed appropriate by the school.

YES / NO
(please circle one)

Note to parents: In the event of an emergency where a parent cannot be reached and has not given permission for the school to admit a child to the hospital, the school administration will make a determination for medical services which will best support the child's needs. This could include seeing a doctor or admission to a hospital of the school's designation.

Date: ____ / ____ / ____
Day Month Year

Signature: _____
(Parent or Guardian)

Printed Name: _____