DEUTSCHE SCHULE KOBE INTERNATIONAL

DAS Deutsche Auslandsschulen International

Student Health File		
Name :		
Has your child ever suffered or is your child currently suffering from any of the following conditions?		
1. Asthma	Yes __ No __	If yes, please give details:
2. Allergies	Yes __ No __	If yes, please give details:
3. Has your child ever shown an allergic reaction to a wasp / bee sting? Yes ___ No ___		
4. Diabetes	Yes __ No __	If yes, please give details:
5. Heart Disease	Yes __ No __	If yes, please give details:
6. Hearing Disorder	Yes __ No __	If yes, please give details:
7. Visual Disorder	Yes __ No __	If yes, please give details:
8. Skin Disorder	Yes __ No __	If yes, please give details:
9. Neuromuscular Disorder	Yes __ No __	If yes, please give details:
10. Orthopedic condition	Yes __ No __	If yes, please give details:
11. Seizure disorder	Yes __ No __	If yes, please give details:
12. Other (Please specify)		
13. Is your child taking any medication regularly? Yes ____ No _____ If yes, please specify: Does medication have to be administered during school hours? Yes ____ No _____		

14. Immunisation Record	
BCG 1. / /	Polio 1. / / 2. / /
DPT Stage 1 1. / / 2. / / 3. / / 4. / /	
DT Stage 2 1. / /	MR 1. / / 2. / / 3. / /
Measles / /	Rubella / /
Mumps / /	Japanese encephalitis 1. / / 2. / / 3. / /
15. Child`s blood type (if known)	
16. Has your child ever been diagnosed with or seen a therapist because of: If yes, please provide copies of all applicable records.	Yes ____ No ____ a) A learning disability: autism, Asperger syndrome, dyslexia, dyscalculia, dysgraphia, attention disorders (e.g. ADHD), _____. b) A developmental delay: speech, language, motor skills, _____. c) Others (please specify) _____ _____
17. Is there anything else we should know?	

I hereby confirm the accuracy and completeness of the above information.

Date: _____
(day/month/year)

Signature: _____