CANADIAN INTERNATIONAL SCHOOL OF SHENYANG
沈阳加拿大外籍人员子女学校

HEALTH QUESTIONNAIRE

Personal Information (To be Completed by the Parents)

Family/Last Name: _____ Given Name(s): _____

学生中文姓名 (if any) :_____ Gender: **Male** ☐ **Female** ☐

Date of Birth (mm/dd/yyyy): _____/_____/_____ Age _____ Religion (if any): _____

Place of Birth: _____ Nationality: _____ First Language: _____

English Fluency: **Fluent** ☐ **Fair** ☐ **Low** ☐ Command of Chinese: **Fluent** ☐ **Fair** ☐ **Low** ☐

Does this student have any brother or sister who is now studying in, applying to or planning to attend this school? **Yes** ☐ **No** ☐

If "Yes", please provide us his/her name: _____ Age:_____ Grade:_____ When? _____/_____/_____

Medical History (To be Completed by the Parents)

1. Please describe any medical condition or history of your child that CISS should be aware of, i.e. Epilepsy, Diabetes, Asthma, Natural Allergies, or any known Allergy to specific chemicals, medicines or substances: _____

_____

2. Does your child take any form of medication (oral or injected) on a regular basis for any of the above? **Yes** ☐ **No** ☐
If "Yes", please provide full details**:**

_____

_____

The school will not administer any medication without the express consent of a parent. If you wish to have medication administered to your child at school, arrangements must be made in advance and a signed Essential Routine Services and Emergency Plan must be provided. Please see the CISS Health Services Policy and appendices available at the Admissions Office for further details.

3. Does your child have any vision problems? **Yes** ☐ **No** ☐ If "Yes", please describe: _____

_____

4. When was your child's vision last checked (mm/dd/yyyy)? _____

_____

5. Does your child have any hearing problems? **Yes** ☐ **No** ☐ If "Yes" please describe: _____

_____

6. Does your child have any speech problems? **Yes** ☐ **No** ☐ If "Yes", please describe: _____

_____

7. Are there any special food considerations? **Yes** ☐ **No** ☐ If "Yes", please describe: _____

_____

The following part must be completed on each page in the presence of a CISS Admissions Officer:

Application Number: A_____ Student Number: S_____ _____ _____

Immunization Records (To be Completed by the Parents or a Physician)

School Policy requires that <u>immunization be current</u> before a student will be admitted to CISS.
Note:

- Parents must provide a photocopy of the current Health Certificate/Card for the child.
- Parents must provide photocopies of the child's vaccination records.
- Immunization procedures vary from country to country. If you have any questions regarding your child's immunization, they should be discussed with your physician.
- Some vaccines are combined or given together (MMR, DPT or Td and OPV). Please enter the date in each appropriate box.
- Parents are reminded to arrange comprehensive medical & accident insurance for their children prior to attending CISS.

Type	1st	2nd	3rd	4th	5th
Polio (TOPV*) Tpi-Oral-Polio-Vaccine *2, 4, 6 & 18 months, 4-6 years, every 10 years*					
Diphtheria, Pertussis, Tetanus (DPT*) 2, 4, 6 & 18 months, 4-6 years, every 5-10 years					
Measles/Mumps/Rubella (MMR*) 15 months; booster by age 11					
Tuberculosis: Vaccine (B.C.G.) or **Test (PPD/Mantoux)** – within one year prior to admission					
Hepatitis B (3 shots)					

Health History (To be Completed by the Parents or a Physician)

Check "Yes", if your child has any of the listed medical conditions and "No", if he/she does not. If "Yes", please provide date (where applicable).

	Yes	No	Date mm/dd/yyyy		Yes	No	Date mm/dd/yyyy
Attention Deficit Disorder (ADD)				**Flu Vaccination**			
Attention Deficit Hyperactivity Disorder (ADHD)				**Glandular Fever**			
Allergies to Foods				**Hay Fever**			
Allergies to Natural Substances				**Heart Disease**			
Allergies to Chemicals				**Hepatitis A ☐ B ☐ C ☐**			
Allergies to Medicines				**Measles (Rubella 10 day)**			
Anaemia				**Mumps**			
Appendectomy				**Poliomyelitis**			
Asthma				**Rheumatic Fever**			
Bone Fractures				**Rubella (German Measles)**			
Chicken Pox				**Scarlet Fever**			
Chicken Pox Vaccination				**Tonsillectomy**			
Ear Infections				**Tuberculosis**			
Eczema				**Whooping Cough**			
Epilepsy				**Other**			
In case of allergies, please specify all the known causes or triggers in detail:							

The undersigned Parents/Guardian of the Student hereby declare(s) that all the information provided in this application, and to the physician conducting the physical examination of the child, relating to the child's health and immunization history are accurate, current, truthful and complete, to the best of my/our knowledge.

Signature of the Parents/Guardian/Date (mm/dd/yyyy)

_____/_____ _____/_____
(Parent/Guardian Signature) (Date-mm/dd/yyyy) (Parent/Guardian Signature) (Date-mm/dd/yyyy)

Print Name: _____ Print Name: _____

Application Number: A_____ Student Number: S_____ _____ _____

Physical Examination (To be Completed by a Physician)

Dear Parents:
To fulfil the entrance requirements of CISS, you must consult a physician for him/her to conduct a physical examination of your child, and assist you to complete this Health Questionnaire. The Student will not be considered for admission until after this form has been returned to CISS.

To the Physician:
Please conduct a physical examination of the Student named below:

Family Name: _____ Given/First/Middle Name: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____ Grade at CISS:_____

Address: _____

Height		**Eyes (Condition)**	**R**	**L**	**Thyroid**	
Weight		**Eyes (Vision)**	**R**	**L**	**Lymph Glands**	
Pulse		**With glasses**	**R**	**L**	**Heart & Circulation**	
Respiration		**With contact lens**	**R**	**L**	**Lungs**	
Blood Pressure		**Colour perception**	**R**	**L**	**Chest**	
Nervous System		**Ears**	**R**	**L**	**Abdomen**	
Nutrition		**Nose**			**Hernia**	
Muscle Tone		**Throat**			**Orthopaedic defects**	
Skin		**Mouth Breathing**			**Scoliosis check**	
Scalp		**Speech Defects**			**Menses**	**Yes ☐ No ☐**
Hair						
Additional Comments (please use a separate page if required):						

Physical Activities (Normal physical education classes, swimming and competitive sports):

Unrestricted: ☐ Modified: ☐

If modified, please explain: _____

Medication:
Is this student taking any medication (oral or injected) on a regular basis? Yes ☐ No ☐
If "Yes", please explain:

_____

Remarks:

Physician's Certificate

I hereby certify that I have conducted a physical examination of _____ (name of student) and that the he/she is physically fit to attend school at Canadian International School of Shenyang.

Physician's Signature/Date (mm/dd/yyyy): _____/_____

Name: _____ Date of Examination (mm/dd/yyyy): _____

Tel: _____ Fax: _____

Address: _____

Application Number: A_____ Student Number: S_____ _____ _____

Emergency Medical Treatment Information

In case of medical emergency, the School staff will attempt to contact the persons indicated in the Emergency Contact Information section of this form to obtain consent for medical treatment of the student. In the event that the School staff is unable to reach any of those contacts, we will transport the Student to the preferred hospital or clinic or, if no preference is indicated below, to the nearest qualified hospital or clinic, for professional medical attention.

Preferred Hospital or Clinic Information

☐ I have no preferred hospital or clinic; or

☐ I prefer that my child be treated at the following hospital or clinic:
Name of Hospital or Clinic:
Address:
Patient Number:
Doctor's Name:

The School reserves the right to transport your child to the nearest qualified hospital or clinic, or to have your child treated by another doctor, pursuant to the terms of the attached Emergency Medical Treatment Authorization, in the event that the nature of the medical emergency makes it impractical to transport your child to your preferred hospital or clinic, or your preferred doctor is not available.

Health Insurance Information

Name of Insurer: _____

Name of Policy Holder: _____

Policy Number: _____

Expiry Date (mm/dd/yyyy): _____

Emergency Contact Information

Contact Priority	First Contact	Second Contact	Third Contact	Family Doctor
Full Name				
中文姓名				
Relationship to Student				
Address				
Home Phone				
Office Phone				
Mobile Phone				
Other Phone				
First Language				
English Proficiency	Fluent ☐ Fair ☐ Low ☐	Fluent ☐ Fair ☐ Low ☐	Fluent ☐ Fair ☐ Low ☐	Fluent ☐ Fair ☐ Low ☐
Chinese Proficiency	Fluent ☐ Fair ☐ Low ☐	Fluent ☐ Fair ☐ Low ☐	Fluent ☐ Fair ☐ Low ☐	Fluent ☐ Fair ☐ Low ☐

Emergency Medical Treatment Authorization

Authorization: The Parent, on behalf of the Parent and the Student, hereby grants authorization to the School to obtain medical care in the event that the Parent is unable to give consent to any emergency medical treatment to the student. The School, its employees or agents, may and are hereby expressly authorized under such circumstances to: (i) seek medical treatment on behalf of the Student in case of emergency or other urgent circumstances; and (ii) provide information regarding the Parent's insurance policy, if any, without incurring any liability, responsibility, or other obligation for the nature, character, and extent of such medical treatment, including without limitation financial liability for the payment of expenses incurred as a result of the treatment of the Student's illness or injuries, and which the Parent hereby acknowledges may exceed the benefits provided by the Parent's insurance policy; and (iii) release personal information to health care providers for the purpose of obtaining emergency medical treatment. The Parent understands and hereby acknowledges that the School may not be able to contact the Parent to approve or obtain consent to the Student's medical treatment. The Parent further understands and hereby acknowledges that any liability of the School arising from or out of its request for or consent to medical treatment necessitated by the Student's illness or injury is specifically included within the releases given below.

Indemnification, Release and Undertaking to Reimburse: The Parent, on behalf of the Parent and the Student, hereby agrees to release, indemnify and hold harmless the School, its officers, directors, principals, employees and agents from any and all expenses, claims and damages arising from the provision of emergency medical treatment to the Student and undertakes to reimburse the School for any expenses incurred by the School in association with the provision of such treatment.

Signature of Parent/Guardian/Date (mm/dd/yyyy):

_____/_____
(Parent/Guardian Signature) (Date-mm/dd/yyyy)

_____/_____
(Parent/Guardian Signature) (Date-mm/dd/yyyy)

Print Name: _____

Print Name: _____

CANADIAN INTERNATIONAL SCHOOL OF SHENYANG
沈阳加拿大外籍人员子女学校

The Canadian International School of Shenyang
develops the whole child, in an environmentally sensitive school, within a kind, caring community, to become a citizen of the world.

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