YOKOHAMA CHRISTIAN SCHOOL

**HEALTH HISTORY INFORMATION**

Child's name: ______________________ Gender: ❒ M ❒ F Date of Birth (M/D/Y) _______________
Father's Work Phone: _____________________ Mother's Work phone: ______________________
Name of Doctor in Japan: __________________ Doctor's Phone: ____________________________
Doctor's Address: ________________________________________________________________

**MEDICAL HISTORY**: *(Please answer all the questions/age at onset)*

| | | | |
|---|---|---|---|
| Asthma: | ❒ No | ❒ Yes | ____________________________________________ |
| Diabetes: | ❒ No | ❒ Yes | ____________________________________________ |
| Heart Disease | ❒ No | ❒ Yes | ____________________________________________ |
| Kidney Disease: | ❒ No | ❒ Yes | ____________________________________________ |
| Seizures: | ❒ No | ❒ Yes | ____________________________________________ |
| Major surgery/Accident: | ❒ No | ❒ Yes | ____________________________________________ |
| ADD/ADHD: | ❒ No | ❒ Yes | ____________________________________________ |
| Aspergers/Autism | ❒ No | ❒ Yes | ____________________________________________ |
| What kind of support is necessary? | | | ____________________________________________ |

Allergies: ❒ No ❒ Yes *If yes, explain below:*
Food: _________________________ Reaction: _______________
Medicine: _________________________ Reaction: _______________
Other: _________________________ Reaction: _______________
Exzema/Frequent Allergies: ❒ No ❒ Yes ______________________________________
Routine medications and reasons for taking them: ________________________________
________________________________________________________________________________

**ILLNESS** to date
Varicella (Chicken Pox) _______________ Measles __________ Mumps ________________
Rubella _________________ Ear Discharge _________________ Other _________________

**IMMUNIZATIONS RECORD** *Please record in detail your child's immunization history with dates or attach a photocopy of your child's medical booklet including immunization details.*

| | | | | | |
|---|---|---|---|---|---|
| DTaP *(Diptheria, Tetnus, Pertussis)*: | 1._____ | 2._____ | 3._____ | 4._____ | 5._____ |
| MMR *(Measles, Mumps, Rubella)*: | 1._____ | 2._____ | | | |
| MR *(Measles, Rubella)*: | 1._____ | 2._____ | | | |
| Polio *(IPV or OPV)*: | 1._____ | 2._____ | 3._____ | 4._____ | |
| Japanese Encephalitis: | 1._____ | 2._____ | | | |
| Hib *(Haemophilus influenza type b)*: | 1._____ | 2._____ | 3._____ | 4._____ | |
| PCV *(Pneumococcal Conjugate)*: | 1._____ | 2._____ | 3._____ | 4._____ | |
| Varicella: | 1._____ | 2._____ | | | |
| Mumps: | 1._____ | 2._____ | | | |
| Hepatitis B: | 1._____ | 2._____ | 3._____ | | |
| Hepatitis A: | 1._____ | 2._____ | 3._____ | | |
| Rotavirus: | 1._____ | 2._____ | 3._____ | | |
| BCG: | 1._____ | | | | |
| Tuberculin test: | 1._____ | | | | |
| Tuberculin test: | Date_______ | Result________ | | | |
| Other: | ____________________________________________ | | | | |

**HEALTHY CHILD POLICY--** Illness can spread quickly at school. Children must be fit and well when they attend. If your child seems unwell, keep him or her at home. If your child appears unwell at school you will be contacted to take him/her home.