

Instructions: Please complete this form as accurately as possible, supplying only local Bali contact information. Return in to the school office before you start school.

Think Globally – Act Locally – Feel Totally

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1. Family Information

Student

Last name: _____

Date of birth: _____

First name: _____

Place of birth: _____

Address: _____

Nationality: _____

Home phone: _____

Father / Guardian

Father's name: _____

Mother / Guardian

Mother's name: _____

Father's work phone: _____

Mother's work phone: _____

Father's mobile phone: _____

Mother's mobile phone: _____

Health insurance company: _____

Health insurance company: _____

Policy number: _____

Policy number: _____

2. Emergency Contact

In the event of an illness, accident or medical emergency, and when neither parent can be reached by telephone, I hereby authorize the following person in the Bali area to give instructions concerning my child until one or both parents can be reached:

Name: _____

Telephone: _____

In the event that school is unable to contact either the parents or their designated emergency contact, the school will act in " loco parentis" until one or both of the parents can be reached. **It is the responsibility of the parents to supply the school with up-to-date contact information.**

3. Health Information

Does your child have any chronic medical conditions that the school should be aware of (for example diabetes, epilepsy, asthma)?

 Yes **No**

If yes, please describe:

Does your child have any allergies?

 Yes **No**

If yes, please describe:

Is your child currently under medical care or taking medications regularly?

 Yes **No**

If yes, please describe:

4. Health Information (continued from page 1)

Does your child wear glasses / contacts?

 Yes **No**

Does your child have any hearing difficulties?

 Yes **No**

If yes, please describe:

Has your child ever had surgery?

 Yes **No**

If yes, please give details:

Does your child have any restrictions with respect to physical activity?

 Yes **No**

If yes, please describe:

Is there any additional health information of which you feel the school should be aware? **Yes** **No**

If yes, please describe:

5. Immunization Record

Please supply the dates (day / month / year) of the most recent immunizations:

Diphtheria: _____

Tetanus: _____

Whooping Cough: _____

Polio: _____

Measles: _____

HIB: _____

Mumps: _____

Hepatitis: _____

Rubella: _____

Other: _____

6. Please Sign This Form Below. Thank You.

I, the parent (or guardian) of the above student, declare that I have answered the questions about his / her health record to the best of my ability and have not withheld any information. I also understand that the school does not carry accident insurance on its students and that it is my responsibility to provide for such insurance. I further understand and accept that the school will act within its capacity to provide for the immediate physical well-being of every student during the time he/she is on school premises but that it cannot provide major medical assistance to students.

Parent Signature: _____

Date (day / month / year) _____