 **MEDICAL HISTORY** *page 2 of 3*

*(additional pages can be attached if needed)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Last Name** |  | **First Name** |  |

* **Please check if your child has, or has had, any of the following health conditions** *(if any of these or other chronic conditions are checked,* ***an* \**Individualized Medical Plan will be required****, see box below):*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Epilepsy | ADD/ADHD | Diabetes | Tuberculosis | Asthma | HIV positive |
| Severe allergy**\***  *(see below)* | | Other  *(please specify)* | | | |

* **My child has been prescribed an EPIPEN (epinephrine/adrenaline auto-injector) and we authorize school personnel to administer the EPIPEN in case of severe allergic reaction.**
* Signature: Date:
* **Please describe any other health condition or physical impairment which the teachers and school nurse**

|  |  |
| --- | --- |
| **must be aware of:** |  |
|  |  |

* An **Individualized Medical Plan (IMP)** or Projet d’Accueil Individualisé (PAI) must be filled out by your child’s doctor for conditions such as: **diabetes, asthma, severe food allergy, epilepsy, or *any condition* requiring regular or emergency medication or treatment**. This plan will enable the School Nurse to manage your child’s health in conjunction with the teaching team.
* The IMP form can be obtained from the Admissions Office or from the ASP School Nurse.
* Do not hesitate to contact the ASP School Nurse for any questions at: nurse@asparis.fr.
* **Please check which of the following illnesses your child has had:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chicken Pox | Measles | Rubella | Mumps | Scarlet Fever |

|  |  |  |
| --- | --- | --- |
| * Is your child subject to headaches? | Yes  No | |
| * Is your child subject to earaches? | Yes  No | |
| * Has your child had an operation? | Yes  No | If yes, reason and date |
|  | | |

|  |  |  |
| --- | --- | --- |
| * Does your child have any specific dietary needs? | Yes  No | If yes, please explain: |
|  | | |
| * Does your child take any medication regularly? | Yes  No |  |
| **If yes**, please explain and include a **copy of any prescriptions** *(no treatment will be administered without up to date medication and a doctor’s prescription):* | | |

* **Please check below:**

**I authorize the school nurse to give my child over the counter medications as needed.**

**I have no objection to my child receiving a blood transfusion in case of serious injury.**

***\*\*\* I hereby certify that the information above is accurate and complete. \*\*\****

Parent/Guardian Signature Date

|  |  |
| --- | --- |
| If you will not be covered under French Securité Sociale please indicate the name and address of your private medical insurance company: |  |