TAIPEI ADVENTIST AMERICAN SCHOOL

EST 1955

STUDENT HEALTH RECORD

STUDENT'S FULL NAME: _____

(LEGAL NAME IN PASSPORT, BOTH ***ENGLISH*** AND ***CHINESE***)

FORMS ARE TO BE COMPLETED BY THE STUDENT'S PARENTS (OR LEGAL GUARDIANS) AND LICENSED PHYSICIAN

CONFIDENTIAL

The information contained within forms will only be available to school supervisory staff and the attending medical practitioner.

TAIPEI ADVENTIST AMERICAN SCHOOL

EST 1955

HEALTH EXAMINATION
FORM H1

_____ D.O.B _____ Sex_____ Grade_____
(Last name) (First name) Yr. M. D.

Height: _____ Weight:_____

Head/ Neck: _____

Ears: _____

Eye-General: _____ Vision Fields: _____

Lungs/ Chest:_____

Heart – rate: _____ B. P._____ Murmurs: _____

Musculoskeletal – extremities: _____ Spine: _____

Scoliosis check: _____

Abdomen – general: _____

Urinalysis – protein: _____

Hemoglobin: _____

Recommendations for activity: ***Physical Education?*** _____ Restricted _____

Comments: _____

_____

_____

_____ _____
Date Signature of Physician

- **Form H1 is to be completed by a licensed physician only.**

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EST 1955

STUDENT HEALTH RECORD
FORM H2

Name: _____ D.O.B: _____ Sex: _____
(last name) (first name) (middle) (year/month/day)

Grade	Year

Father: _____ Address: _____

Mother: _____ _____

Home Phone: _____ Other Children at TAAS: _____

E-Mail: _____ _____

Business Phone: _____
(Father)

_____
(Mother)

Cell Phone: Father _____ Mother _____

If unable to contact parents, call: 1. _____ Phone: _____

2. _____ Phone: _____

HEALTH HISTORY

Did your child have any problems at birth? Yes _____ No_____ if yes, please explain.

_____

Was there any delay in growth and development (walking, talking, etc.)? No _____ Yes_____
If yes, please explain, _____

_____

Disease History (give age):				Health Problem/Doctor Diagnosed (give age):			
Rheumatic Fever		Mumps		Allergy		Visual Problems	
Chicken Pox		Scarlet Fever		Asthma		Hearing Loss	
German Measles		Chronic Ear Infect.		Heart Disease		Seizure Disorder	
Measles		Urinary Tract Infect.		Diabetes		Orthopedic	
Other				Other		ADHD/ADD	

Allergies: Food, environment, medications. Yes___ No___ if yes, please describe reaction and treatment including medications taken:

Describe any serious illness, operations, injuries, or hospitalizations:
Medications taken on a regular basis: _____

IMMUNIZATIONS (This record must be completed by school personnel from an immunization record provided by parent or guardian.)

Vaccine	Date of Immunization				
	1st	2nd	3rd	Booster	Booster
*Polio					
Polio (Additional Boosters)					
*Diphtheria/Pertussis/Tetanus					
Diphtheria/Tetanus Boosters					
Hepatitis B					
Varicella		Not required if child had Chicken Pox			
Measles (Rubella)			Measles, Mumps, Rubella, may be given in Combinations called MMR or M.R.		
Mumps					
Rebella (German Measles)					
Covid 19					

❖ Initial Series usually given in infancy

Permission for minor medications (Children's Tylenol/Panamax/Panadol/Ibuprophen/Benadryl) Yes_____ No_____

I hereby certify that the child named above has received the immunizations indicated.
I hereby consent to emergency hospital treatment for my child.

_____ _____
Parent/ Guardian Signature Date

- **Form H2 is to be completed by a licensed physician only.**

TAIPEI ADVENTIST AMERICAN SCHOOL

RECORD AT TAAS
FORM H3

School Year																
	Grade															
VISION	Date															
	R															
	L															
	Both															
	Glasses/contact lenses															
HEARING	Date															
	1000															
	R 2000															
	4000															
	1000															
	L 2000															
	4000															
SCOLIOSIS	Date															
	results															

Health & Accident Record at TAAS

Amended July 2021