

Student Health Record

KAOHSIUNG AMERICAN SCHOOL

學生健康紀錄

Student's Last Name _____ First Name _____ Middle Initial _____
(學生的姓) (學生的名) (學生中間名)

Date of birth (MM/DD/YY) ____/____/____ Male (男) Female (女)
(生日 月份/日期/年份)

Contact Information (聯絡資訊):

Parent/guardian's Name _____
(家長/監護人姓名)

Home Phone (家中電話) _____ Work Phone (辦公電話) _____
Cellular Phone(s) (手機) _____

Emergency Contacts (緊急連絡人) _____

(friend, neighbor or business associate to contact in an emergency if the parent/guardian were to be unavailable)

(若父母/監護人無法聯絡時之緊急聯絡人, 如朋友, 鄰居或工作相關人員)

Home Phone (家中電話) _____ Work Phone (辦公電話) _____
Cellular Phone(s) (手機) _____

The nurse has my permission to give over-the-counter remedies (Tylenol/Panadol/Antacid), if necessary:

若有需要, 學校護士可以為我孩子使用非處方藥(如Tylenol/Panadol/Antacid)

Check Yes No (請勾選是/否) Parent/Guardian Signature(家長/監護人簽名) _____

Student's Significant Past History: (circle & list approximate year, i.e. Chicken Pox 1992)

(學生病史 -- 圈選並標示發病年份, 例如 水痘 1992)

Measles (麻疹)	German Measles (德國麻疹)	Mumps (腮腺炎)
Asthma (氣喘)	Chicken Pox (水痘)	Scarlet Fever (黃熱病)
Diphtheria (白喉)	Hepatitis (肝炎)	Intestinal parasites (腸阻塞)
Heart Disease (心臟疾病)	Encephalitis (腦膜炎)	Nephritis (腎臟炎)
Rheumatic Fever (風濕熱)	Diabetes (糖尿病)	Tuberculosis (肺結核)
Epilepsy (癲癇)	Allergy (過敏)	Seizure Disorder(抽搐)
Other (其它): _____		

Medications (circle): Yes No (請勾選是/否) _____
(使用藥物) (daily and occasional)/(每日或偶爾)

Allergies Yes No (請勾選是/否) _____
(過敏) (please specify: food, insect, medication, etc.)(食物, 蟲子, 藥物)

Surgery Yes No (請勾選是/否) _____
(手術) (please specify and give dates)(請註明日期)

Emotional problems (情緒障礙): Yes No (請勾選是/否) _____

Special health conditions, significant family history, parental concerns

(任何健康問題, 重要家族病史, 父母關心問題) _____

Information provided by: _____

Signature of parent or guardian(監護人簽名)

Date(日期)