



Student Health History 健康记录表

Student's Name/学生姓名 _____ Date of Birth/生日 _____

Grade/申请年级 _____ Gender/性别 _____

Please check the immunizations your child has received and attach a copy of the child's immunization record 家长请提供孩子的免疫记录，并请提供孩子最近的免疫记录附件：

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Measles 麻疹 | <input type="checkbox"/> Mumps腮腺炎 | <input type="checkbox"/> Rubella 风疹疫苗 |
| <input type="checkbox"/> Typhoid伤寒 | <input type="checkbox"/> Hepatitis B B型肝炎 | <input type="checkbox"/> Pertussis (Whooping Cough)百日咳 |
| <input type="checkbox"/> Polio 麻痹症 | <input type="checkbox"/> TB 肺癆 | <input type="checkbox"/> Diphtheria /Tetanus 白喉/破伤风 |

Does your child have any of the following? 你孩子有以下的健康问题吗？

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Heart Disease/心脏病 | <input type="checkbox"/> Head Injury/头部受伤 | <input type="checkbox"/> Epilepsy/羊痫风 | <input type="checkbox"/> Asthma/哮喘 |
| <input type="checkbox"/> Stomach problems/胃病 | <input type="checkbox"/> Diabetes/糖尿病 | <input type="checkbox"/> Skin Disease/皮肤病 | <input type="checkbox"/> Allergies/过敏 |
| <input type="checkbox"/> Eye/Ear Problems/眼睛或耳朵疾病 | <input type="checkbox"/> Menstrual Problems/月经问题 | <input type="checkbox"/> Tuberculosis/肺癆 | |
| <input type="checkbox"/> Frequent headaches/经常头疼 | <input type="checkbox"/> Neurological Disorder/神经失调 | <input type="checkbox"/> Frequent nose bleeds 流鼻血 | |
| <input type="checkbox"/> Psychological Disorders 智力/精神健康问题 | <input type="checkbox"/> Any Infectious Disease/任何传染性疾病 | <input type="checkbox"/> Other/其它 | |

Please attach any relevant information or medical reports to explain any issues checked above or any other medical issues the school should be aware of. 请附加与上述有关的学生健康报告或值得学校注意的健康问题。

Does your child take medication routinely? 是否服用某种常规药品？ Yes/是 No/否

If yes, please explain 如有，请详列：

(Please note, medications can only be taken at school when dispensed by the school nurse and with written permission of parents) 请注意：在学校服用的药品，需校医发配，并获得家长的书面认可。

Does your child have any allergies? If yes, please list all allergies to food or environment.

您的小孩是否对某种食物或环境过敏，如有，请详述：

Does your child wear glasses or contact lenses?你孩子带眼镜或隐形眼镜吗？ Yes/是 No/否

Does your child have any conditions which limit physical activity? 你孩子是否有健康问题会影响体育活动吗？

Yes/是 No/否 If yes, please explain 如有，请详列：



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Current Contact Numbers 父母联系信息

Father's Name/父亲

Phone 电话/Home 家庭 Mobile/手机 Office/办公室

Mother's Name/母亲

Phone 电话/Home 家庭 Mobile/手机 Office/办公室

Emergency Contact Other Than Parents /紧急联系人

Please provide information of two local residents we can contact in the event we cannot reach you in an emergency:
如紧急时，联系不到父母亲请列明两位住在深圳的紧急联系人：

1. Name/姓名 Relationship to family/关系

Phone 电话/Home 家庭 Mobile /手机

2. Name/姓名 Relationship to family/关系

Phone 电话/Home 家庭 Mobile/手机

BCIS transports emergency cases to the nearest hospital. If you would like your child taken to another hospital, please indicate which one:

如有紧急情况发生，曦城协同学校会送学生到就近的医院，如果您想将您的小孩送到其他医院，请指定：

Doctor is Information 指定医生

Name of Pediatrician/医生姓名 Phone Number of Clinic/医疗室电话

I hereby give permission for BCIS to initiate emergency measures in the event of an accident or sudden, serious illness. I understand that the school will try immediately to contact me, or if I am unreachable, the emergency contacts listed above. I also give permission for the school health staff to dispense routine first aid to my child for such conditions as cuts, abrasions, stomach ache, and headache. I affirm that all information given on this health record, as in the rest of the application, is complete and accurate. I understand that I am responsible for all medical fees incurred.

我特此声明在紧急时授权曦城协同学校采取相应措施。我清楚曦城协同学校在我的孩子发生紧急情况是立即联系我，若我不能联系到，将联系我列出的紧急联系人。我授权学校医护人员在我孩子有擦伤、胃疼或头疼等症状时给予常规的第一时间治疗。我声明本人在此表中提供的信息和附加的报告真实并完整。同时，我理解如果遇到任何紧急情况我的孩子被送至医院治疗，我将承担所有相关的费用。

Signature of Parent/家长签字 Date/日期