SEOUL AMERICAN ELEMENTARY/MIDDLE/HIGH SCHOOLS

SCHOOL HEALTH UPDATE

Student's Name: _____ School Year 2000-2001
(Last) (First) (Middle)

Birth Date: _____ Next Year's School Grade: _____
(Day) (Month) (Year)

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Health History

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	(Circle)		(Circle)		
1. Does your child wear glasses or contact lenses?	No	Yes	Always	Near Work	Far Work
2. Does your child have a hearing problem?	No	Yes	Right Ear	Left Ear	
3. Does your child wear a hearing aid?	No	Yes	Right Ear	Left Ear	
4. Does your child have scoliosis?	No	Yes			
5. Does your child have any allergies?	No	Yes	To What? _____		
6. Has your child ever had a positive reaction to a tuberculin skin test? (IPPD or Tine)	No	Yes	When? _____		
7. Has your child had the chickenpox disease?	No	Yes	When? _____ Month/Year		
8. Does your child have asthma?	No	Yes			
9. Does your child take medications or use an inhaler at home regularly?	No	Yes	_____ (Name of Medication)		
10. Does your child need to use an inhaler or take medications at school?	No	Yes	_____ (Name of Medication)		
11. Does your child have any other health problems that the school should know about?	No	Yes	What? _____		

_____ Parent's/Sponsor's Signature

_____ Date

Work Phone _____ Home Phone _____ Cell Phone _____