

Shanghai High School International Division

Medical Form of Student Applying for Admission

Please complete all information requested on this form.

This form must be completed in its entirety with the submit of application form.

1. Student Information

Name of Student: _____ Gender: M / F

(as on passport) Family Name First Name Middle Name

Grade Applied for: _____ Date of Birth: _____ Country of Passport _____

2. Student Medical History

Allergies (<i>food, meds, insect, seasonal</i>)		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Hearing problems	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
Asthma		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Heart diseases	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
Diabetes		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Hepatitis A/B/C	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
Epilepsy / Seizure Disorder		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Obsession	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
ADD/ADHD		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
Anxiety		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Skin problems	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
Gastrointestinal Disorder		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Speech difficulty	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
Arthritis		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Vision problems	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
Depression		<input type="checkbox"/> Yes/ <input type="checkbox"/> No	Other illness	<input type="checkbox"/> Yes/ <input type="checkbox"/> No

If you have answered **YES** to any of the above, or your child has any additional medical concerns, or particular problem that needs special attention, please explain in detail: _____

3. Emergency Care Permission

Emergency Contact Person:

Emergency Contact person #1: Name: _____ Relationship to student: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

Emergency contact person #2: Name: _____ Relationship to student: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

➤ Under general circumstance, will you allow your child to be treated at the school clinic? Yes ___ No ___

➤ In case requiring emergency medical attention and if reasonable efforts to contact parents and emergency contact persons are unsuccessful, will you allow your child to be sent to the public hospital for the treatment? Yes ___ No ___

If No, which hospital do you want the child to be sent to? Please name your preferred **Shanghai Medical Facility** /

Doctor: _____

Students insurance at school only cover the public hospital in Shanghai. If you want your child to be treated in the private hospital, you need to pay the medical fee by yourself.

I acknowledge that I am responsible for updating the contact information and student health information provided herein to SHSID and that all information I have provided on this document is complete and correct.

I am fully responsible for any consequences caused by incorrect or incomplete information I provide.

Parent Signature: _____
Print Name: _____ Date: _____ / _____ / _____
month day year