



HEALTH QUESTIONNAIRE

Personal Information (To be Completed by the Parents)

Family/Last Name: _____ Given Name(s): _____

学生中文姓名 (if any): _____ Gender: **Male** **Female**

Date of Birth (mm/dd/yyyy): ____/____/____ Age ____ Religion (if any): _____

Place of Birth: _____ Nationality: _____ First Language: _____

English Fluency: **Fluent** **Fair** **Low** Command of Chinese: **Fluent** **Fair** **Low**

Does this student have any brother or sister who is now studying in, applying to or planning to attend this school? **Yes** **No**

If "Yes", please provide us his/her name: _____ Age: ____ Grade: ____ When? ____/____/____

Medical History (To be Completed by the Parents)

1. Please describe any medical condition or history of your child that CISS should be aware of, i.e. Epilepsy, Diabetes, Asthma, Natural Allergies, or any known Allergy to specific chemicals, medicines or substances: _____

2. Does your child take any form of medication (oral or injected) on a regular basis for any of the above? **Yes** **No**
If "Yes", please provide full details: _____

The school will not administer any medication without the express consent of a parent. If you wish to have medication administered to your child at school, arrangements must be made in advance and a signed Essential Routine Services and Emergency Plan must be provided. Please see the CISS Health Services Policy and appendices available at the Admissions Office for further details.

3. Does your child have any vision problems? **Yes** **No** If "Yes", please describe: _____

4. When was your child's vision last checked (mm/dd/yyyy)? _____

5. Does your child have any hearing problems? **Yes** **No** If "Yes" please describe: _____

6. Does your child have any speech problems? **Yes** **No** If "Yes", please describe: _____

7. Are there any special food considerations? **Yes** **No** If "Yes", please describe: _____

The following part must be completed on each page in the presence of a CISS Admissions Officer:

Application Number: A _____ Student Number: S _____

Immunization Records (To be Completed by the Parents or a Physician)

School Policy requires that immunization be current before a student will be admitted to CISS.

Note:

- Parents must provide a photocopy of the current Health Certificate/Card for the child.
- Parents must provide photocopies of the child's vaccination records.
- Immunization procedures vary from country to country. If you have any questions regarding your child's immunization, they should be discussed with your physician.
- Some vaccines are combined or given together (MMR, DPT or Td and OPV). Please enter the date in each appropriate box.
- Parents are reminded to arrange comprehensive medical & accident insurance for their children prior to attending CISS.

Type	1 st	2 nd	3 rd	4 th	5 th
Polio (TOPV*) Tpi-Oral-Polio-Vaccine <i>2, 4, 6 & 18 months, 4-6 years, every 10 years</i>					
Diphtheria, Pertussis, Tetanus (DPT*) <i>2, 4, 6 & 18 months, 4-6 years, every 5-10 years</i>					
Measles/Mumps/Rubella (MMR*) <i>15 months; booster by age 11</i>					
Tuberculosis: Vaccine (B.C.G.) or Test (PPD/Mantoux) – within one year prior to admission					
Hepatitis B (3 shots)					

Health History (To be Completed by the Parents or a Physician)

Check "Yes", if your child has any of the listed medical conditions and "No", if he/she does not. If "Yes", please provide date (where applicable).

	Yes	No	Date mm/dd/yyyy		Yes	No	Date mm/dd/yyyy
Attention Deficit Disorder (ADD)				Flu Vaccination			
Attention Deficit Hyperactivity Disorder (ADHD)				Glandular Fever			
Allergies to Foods				Hay Fever			
Allergies to Natural Substances				Heart Disease			
Allergies to Chemicals				Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>			
Allergies to Medicines				Measles (Rubella 10 day)			
Anaemia				Mumps			
Appendectomy				Poliomyelitis			
Asthma				Rheumatic Fever			
Bone Fractures				Rubella (German Measles)			
Chicken Pox				Scarlet Fever			
Chicken Pox Vaccination				Tonsillectomy			
Ear Infections				Tuberculosis			
Eczema				Whooping Cough			
Epilepsy				Other			
In case of allergies, please specify all the known causes or triggers in detail:							

The undersigned Parents/Guardian of the Student hereby declare(s) that all the information provided in this application, and to the physician conducting the physical examination of the child, relating to the child's health and immunization history are accurate, current, truthful and complete, to the best of my/our knowledge.

Signature of the Parents/Guardian/Date (mm/dd/yyyy)

_____/_____
(Parent/Guardian Signature) (Date-mm/dd/yyyy)

_____/_____
(Parent/Guardian Signature) (Date-mm/dd/yyyy)

Print Name: _____

Print Name: _____

Application Number: A _____ Student Number: S _____

Physical Examination (To be Completed by a Physician)

Dear Parents:

To fulfil the entrance requirements of CISS, you must consult a physician for him/her to conduct a physical examination of your child, and assist you to complete this Health Questionnaire. The Student will not be considered for admission until after this form has been returned to CISS.

To the Physician:

Please conduct a physical examination of the Student named below:

Family Name: _____ Given/First/Middle Name: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____ Grade at CISS: _____

Address: _____

Height		Eyes (Condition)	R	L	Thyroid	
Weight		Eyes (Vision)	R	L	Lymph Glands	
Pulse		With glasses	R	L	Heart & Circulation	
Respiration		With contact lens	R	L	Lungs	
Blood Pressure		Colour perception	R	L	Chest	
Nervous System		Ears	R	L	Abdomen	
Nutrition		Nose			Hernia	
Muscle Tone		Throat			Orthopaedic defects	
Skin		Mouth Breathing			Scoliosis check	
Scalp		Speech Defects			Menses	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hair						

Additional Comments (please use a separate page if required):

Physical Activities (Normal physical education classes, swimming and competitive sports):

Unrestricted: Modified:

If modified, please explain: _____

Medication:

Is this student taking any medication (oral or injected) on a regular basis? Yes No

If "Yes", please explain: _____

Remarks:

Physician's Certificate

I hereby certify that I have conducted a physical examination of _____ (name of student) and that the he/she is physically fit to attend school at Canadian International School of Shenyang.

Physician's Signature/Date (mm/dd/yyyy): _____ / _____

Name: _____ Date of Examination (mm/dd/yyyy): _____

Tel: _____ Fax: _____

Address: _____

Emergency Medical Treatment Information

In case of medical emergency, the School staff will attempt to contact the persons indicated in the Emergency Contact Information section of this form to obtain consent for medical treatment of the student. In the event that the School staff is unable to reach any of those contacts, we will transport the Student to the preferred hospital or clinic or, if no preference is indicated below, to the nearest qualified hospital or clinic, for professional medical attention.

Preferred Hospital or Clinic Information

- I have no preferred hospital or clinic; or
- I prefer that my child be treated at the following hospital or clinic:
 Name of Hospital or Clinic:
 Address:
 Patient Number:
 Doctor's Name:

The School reserves the right to transport your child to the nearest qualified hospital or clinic, or to have your child treated by another doctor, pursuant to the terms of the attached Emergency Medical Treatment Authorization, in the event that the nature of the medical emergency makes it impractical to transport your child to your preferred hospital or clinic, or your preferred doctor is not available.

Health Insurance Information

Name of Insurer: _____

Name of Policy Holder: _____

Policy Number: _____

Expiry Date (mm/dd/yyyy): _____

Emergency Contact Information

Contact Priority	First Contact	Second Contact	Third Contact	Family Doctor
Full Name				
中文姓名				
Relationship to Student				
Address				
Home Phone				
Office Phone				
Mobile Phone				
Other Phone				
First Language				
English Proficiency	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>
Chinese Proficiency	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>	Fluent <input type="checkbox"/> Fair <input type="checkbox"/> Low <input type="checkbox"/>

Emergency Medical Treatment Authorization

Authorization: The Parent, on behalf of the Parent and the Student, hereby grants authorization to the School to obtain medical care in the event that the Parent is unable to give consent to any emergency medical treatment to the student. The School, its employees or agents, may and are hereby expressly authorized under such circumstances to: (i) seek medical treatment on behalf of the Student in case of emergency or other urgent circumstances; and (ii) provide information regarding the Parent's insurance policy, if any, without incurring any liability, responsibility, or other obligation for the nature, character, and extent of such medical treatment, including without limitation financial liability for the payment of expenses incurred as a result of the treatment of the Student's illness or injuries, and which the Parent hereby acknowledges may exceed the benefits provided by the Parent's insurance policy; and (iii) release personal information to health care providers for the purpose of obtaining emergency medical treatment. The Parent understands and hereby acknowledges that the School may not be able to contact the Parent to approve or obtain consent to the Student's medical treatment. The Parent further understands and hereby acknowledges that any liability of the School arising from or out of its request for or consent to medical treatment necessitated by the Student's illness or injury is specifically included within the releases given below.

Indemnification, Release and Undertaking to Reimburse: The Parent, on behalf of the Parent and the Student, hereby agrees to release, indemnify and hold harmless the School, its officers, directors, principals, employees and agents from any and all expenses, claims and damages arising from the provision of emergency medical treatment to the Student and undertakes to reimburse the School for any expenses incurred by the School in association with the provision of such treatment.

Signature of Parent/Guardian/Date (mm/dd/yyyy):

_____/_____
(Parent/Guardian Signature) (Date-mm/dd/yyyy)

_____/_____
(Parent/Guardian Signature) (Date-mm/dd/yyyy)

Print Name: _____

Print Name: _____



CANADIAN
INTERNATIONAL SCHOOL OF
SHEN YANG
沈阳加拿大外籍人员子女学校

The Canadian International School of Shenyang
develops the whole child, in an environmentally sensitive school, within a kind, caring community,
to become a citizen of the world.

学校地址：沈阳市浑南区辉山301

Web: www.cisshenyang.com.cn

No.301 Hui Shan Road, Hunnan District, Shenyang, 110167, P.R. China

E-mail: syadmissions@cisshenyang.com

Tel:86-24-66675379/ 66684109