



**West Nairobi School Student Health Assessment**  
*No admissions will be processed without the completion of this form*

**Part 1: Student Health Assessment (to be completed by Parent/Guardian)**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name Middle Name (Day/month/year)

**Part 2: Health Evaluation (to be completed by your Physician)**

Health Examination Date: \_\_\_\_\_ (evaluation must be done after child is 3 years of age for Pre-K)

Blood Type \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**For Pre-K students:** Eyes \_\_\_\_\_ Vision R 20/ \_\_\_\_\_ L/20 \_\_\_\_\_ with or without corrective device (circle one)

Ears \_\_\_\_\_ Hearing R \_\_\_\_\_ L \_\_\_\_\_

**Is there any evidence for concern in the areas listed below? Please check the results of your examination.**

Allergies (Drugs, Food, Insects) Yes  If "Yes" please indicate what and reaction suffered:

\_\_\_\_\_

- |                    |                              |                 |                              |
|--------------------|------------------------------|-----------------|------------------------------|
| Vision             | Yes <input type="checkbox"/> | Hearing         | Yes <input type="checkbox"/> |
| Asthma             | Yes <input type="checkbox"/> | Speech          | Yes <input type="checkbox"/> |
| Behavior/Emotional | Yes <input type="checkbox"/> | Development     | Yes <input type="checkbox"/> |
| Diabetes           | Yes <input type="checkbox"/> | ADD/ADHD        | Yes <input type="checkbox"/> |
| Seizures           | Yes <input type="checkbox"/> | Bladder         | Yes <input type="checkbox"/> |
| Birth Defects      | Yes <input type="checkbox"/> | Bowel           | Yes <input type="checkbox"/> |
| Cerebral Palsy     | Yes <input type="checkbox"/> | Activity Limits | Yes <input type="checkbox"/> |
| Heart              | Yes <input type="checkbox"/> |                 |                              |

No concerns in the areas listed above

**Part 3: Immunization History**

*Vaccination is a proven tool for controlling and even eradicating infectious diseases. It is an easier and less risky way to become immune. It protects not just the individual but an entire community.*

**Compulsory Vaccines (Please indicate dates given, or attach a copy of the records)**

BCG or PPD (Tine Test) \_\_\_\_\_

Diphtheria/Pertussis/Tetanus (DTP): No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_

No. 4 \_\_\_\_\_ No. 5 \_\_\_\_\_ No. 6 \_\_\_\_\_

Polio (OPV or IPV): No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_ No. 4 \_\_\_\_\_ No. 5 \_\_\_\_\_

Measles, Mumps, Rubella (MMR): No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_

Yellow Fever: \_\_\_\_\_

**Recommended Vaccines:**

Hepatitis B: No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_

Hepatitis A: No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_

Hib: No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_ No. 4 \_\_\_\_\_

Tetanus Booster: \_\_\_\_\_

Varicella: \_\_\_\_\_ (If child has not had Chicken Pox before starting school)

**Part 4: Additional Information from Medical Practitioner**

The above mentioned student has had a complete history and physical examination, and is free of infection or contagious diseases and can participate in normal school activity? Yes  No

If no, please state condition or limitations.

\_\_\_\_\_  
\_\_\_\_\_

Name of Medical Examiner: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address of Medical examiner: \_\_\_\_\_

Email of Medical Examiner: \_\_\_\_\_

\_\_\_\_\_  
Signature and Stamp of Medical Examiner Date

**Part 5: Medications**

**Please check if you grant permission to West Nairobi School to administer the following non-prescription medications to your child.**

Antacid Tablet  Throat Lozenges  Ear Drops  Eye Drops  Panadol (Paracetamol/Tylenol)   
Ibuprofen  Piriton (antihistamine)

Is your child taking any medication regularly at home? Yes  No

If yes, Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Purpose \_\_\_\_\_

**Additional Parent comments to the School Health Officer:**

\_\_\_\_\_  
\_\_\_\_\_

**In case of medical emergency, please note that your child will be transported to Karen Hospital, located on Lang’ata Road in Karen.**

In the event of “NO WARNING” civil disorder during the school day prohibiting safe travel, I grant West Nairobi School authority to assume custody of my child, without liability to West Nairobi School.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_