LCS International Student Medical Profile

Physical assessment by a medical doctor must be completed within 6 months of arrival to Lincoln Christian School.

Immunizations must be completed before arriving.

<u>Immunization Information Required</u>

3 DTP (at least 1 > 4 years old) **Tdap** is required for all students (This is the tetanus/pertussis booster)
3 Polio (either oral or IPV)
2 MMR (the first after 12 months of age)
3 Hepatitis B (the first two separated by one month, then the last is 5 months after the 2nd in the series.)
2 Varicella (ALL students must have *either* documentation of the chicken pox disease *or* 2 varicella shots.

THIS FORM DOES NOT REPLACE THE IMMUNIZATIONS FORM – BOTH MUST BE COMPLETED IN ENGLISH AND RETURNED. SEE IMMUNIZATION FORM.

Students Complete Name____

Students Date of Birth ______________________________________

Emergency Contact Name in United States________________________________

Phone Number#__________________ Address______________________________

Emergency Contact Name in Home Country_______________________________________

Phone Number#_________________ Address__________________________________

Preferred Doctor ____

Preferred Hospital_______________________________________

Insurance Company Name____________________________Phone#____________________

Allergies & Reactions: If any, Medication Name ____________________________________

If any, Food or Environmental allergy reactions:______________________________________

Other Medications Student is taking____

Existing Medical Condition(s)____

Past Surgery(s) and Date____

NO BLANKS ARE PERMITTED, THIS FORM MUST BE COMPLETELY FILLED OUT.

Documentation of Varicella (Chickenpox) Disease

(To be filled out by the parent, guardian, or medical provider of the child / student)

This form is used **ONLY** if child **HAD** the **Chickenpox DISEASE**

This document is being submitted on behalf of: *(Name of child / student)*

____

First *Middle* *Last*

_____________ / _______ / _____________

(Birthdate of child / student) mm/dd/yyyy

I, ____, verify that the above listed

Parent/Guardian/Medical Provider

Child / student **HAD** the **Varicella DISEASE** in ______________ (*year*).

THIS FORM NOT NEEDED IF CHILD HAD SHOT

____

(Signature of parent/guardian/medical provider)

____

(Date)