



Ambrit International School
Via Tajani 50, 00149 Rome
Tel: 06 5595305 FAX: 06 5595309
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Health Record

Confidential

Enter or correct the information below.

DATE

LAST NAME FIRST NAME GENDER
 BIRTH DATE PARENT/GUARDIAN
 BIRTHPLACE STREET
 FAMILY DR CITY ZIP
 DR TEL HOME PHONE CELL

Health History

PAST DISEASES - Enter approximate date

ALLERGIES

MEDICATIONS

REASON

VISION

DATE

HEARING

DATE

HOSPITALIZATION - Enter hospitalization/surgical treatment/professional counseling or therapy.

If there is anything else we should know about your child's health, please comment below.

Vaccinations Record

Enter date of immunization vaccinations and boosters. Attach copies of vaccination certificates not already submitted.

DPT/DT SERIES MMR
 POLIO SERIES MENINGITIS
 HEPATITIS B
 OTHER VACCINES

Signature: _____ Date: _____

I have read the above medical information and attest that the information provided above is true and accurate.

School visual screening (for official use only)

SCREENING DATE

VA RIGHT VA LEFT

GLASSES

FOLLOW UP

PHYSICAL EXAMINATION (To be filled out by a licensed Physician)

Full name of student:

Date of birth: Sex:

Height: Weight:

Eyes:

Ears:

Nose:

Throat:

Heart:

Lungs:

Abdomen:

Hernia:.....

Extremities:

Posture (spine):

Skin:

Menstrual History:

General appraisal:

.....
.....

Recommendations and Restrictions:

.....
.....

I hereby certify that the student does not show signs or symptoms of infectious diseases and is fit for school attendance.

Si certifica che l'alunno/a visitato da me in data odierna, non presenta segni o sintomi di malattie infettive e può frequentare la scuola.

Examining Physician/ Medico esaminatore

Address/Indirizzo Tel.

Date Signature: