Inspire ACADEMY
DREAM. BELIEVE. EXPLORE.

HEALTH INFORMATION FORM AND CERTIFICATION OF IMMUNIZATION

Please complete and return this form to the office at registration. Students exempted from immunizations should provide an Affidavit, documentation from their medical practitioner or certificate of religious exemption under confidential cover to the Principal. Please note, failure to complete and comply with guidelines for the Health Information and Certification of Immunization form may result in the applicant being unable to register or the withdrawal of the offer of a place in our school.

PART 1: DECLARATION BY PARENT

Child's Name____
Last Name *First Name* *Other Name(s)*

Date of Birth___/___/____ **Sex** ☐ **M** ☐**F** **Country of Birth**____________________
dd mm yy

Address____

Name of Parent/Guardian ______________________________

Home________________ **Work**________________ **Cell**________________

Name of Emergency Contact #1 ______________________________

Home________________ **Work**________________ **Cell**________________

Name of Emergency Contact #2 ______________________________

Home________________ **Work**________________ **Cell**________________

MEDICAL QUESTIONNAIRE

1. Has your child been diagnosed with a chronic illness? ☐ Yes ☐ No
   e.g. asthma, cancer, diabetes, epilepsy, hypertension, heart condition
2. Is he/she taking any medication on a regular basis? ☐ Yes ☐ No
   If Yes, name the medication(s) ____
3. Has any member of your family or any person living in your household suffered from or been suspected of suffering from tuberculosis? ☐ Yes ☐ No
   If Yes, give details___________ ____
4. Does your child have any of the following conditions for which he/she may require special accommodation? ☐ Yes ☐ No
   i. Physical Disability______________________________
   ii. Psychological Disorder______________________________
   iii. Learning Disability______________________________
   (including dyslexia, attention deficit/hyperactivity disorder)

If yes, please forward separately under confidential cover to the Principal the supporting documentation from your professional health provider.

5. Does your child have
   i. allergies to food, medicine or chemicals? ☐ Yes ☐ No
   ii. allergies to environmental agents including insects, animal dander, grass? ☐ Yes ☐ No
   iii. allergic conditions such as sinusitis, allergic rhinitis, eczema? ☐ Yes ☐ No

   If Yes, give details___________ ____
   Type of Allergic Reaction**:** ☐ Anaphylaxis ☐ Other_________________________
   Response Required: ☐ None ☐ Epi Pen ☐ Other___________________________
   ☐ **Check here if you want to discuss with the Principal any confidential information indicated above.**

Name Primary Care Physician______________________________ **Tel #**________________

Date of Last Appointment______________________________

PART 2: CERTIFICATION OF IMMUNIZATION

To be completed and signed by a Medical Examiner

Child's Name____

Last Name ***First Name*** ***Other Name(s)***

IMMUNIZATION HISTORY	DATES OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis (DTP, DT, DTaP)	1	2	3	4	5
Poliomyelitis (OPV,IPV)	1	2	3	4	5
Measles, Mumps, Rubella (MMR)	1	2	3	4	5
Varicella	1	2	3	4	5
BCG	1				
Meningococcal *Required for International Students Only*	1				
Hep B , Pneumococcus	1	2	3	4	5
Other					

A copy of the child's immunization record signed and stamped by a physician indicating the child's immunization records will be accepted in lieu of recording the dates in this section.

I certify that this applicant is adequately or age appropriately immunized in accordance with the minimum requirements of the National Expanded Programme on Immunizations (EPI) schedule and Barbados' Health Services (Communicable & Notifiable Diseases Regulation) for adolescents.

Signature of Medical Provider or Health Department Official_________________**Date: ___/___/____**
dd mm yy

CONDITIONAL ENROLLMENT

I certify that this child has received the following vaccines listed below and has a plan for the completion of his/her vaccine requirements. Next immunization due on ________________________________

2 months 1st DPT and Oral/IM Polio, HIB, Hep B & Pneumococcus
4 months 2nd DPT and Oral/IM Polio, HIB, Hep B & Pneumococcus
6 months 3rd DPT and Oral/IM Polio, HIB, Hep B & Pneumococcus
12 months 1st Measles, Mumps. Rebella
18 months 1st Booster DPT & Oral/IM Polio

Signature of Medical Provider or Health Department Official_________________**Date: ___/___/____**
dd mm yy

Health Care Professional's Certification (Affix Official Stamp)
Full Name____
Practice Name____
Address____
Signature ___________________________________ **Date: ___/___/____**
dd mm yy