BURUNDI AMERICAN INTERNATIONAL ACADEMY
KNOWLEDGE PASSION EXCELLENCE
Website: www.baiaexcellence.org
Emails: info@baiaexcellence.org
abriggs@baiaexcellence.org
P.O.BOX: 5986 Bujumbura, Burundi
Telephone: +257 6758 3743
Austin E Briggs Jr. , Director

HEALTH FORM: STUDENT PERSONAL INFORMATION

PART I: Health Assessment

Student Name: _____ Date of Birth: _____

Male____ Female_____ Applying for Grade: _____

Parent Name _____ Parent Telephone: _____

EMERGENCY CONTACT INFORMATION

Please name an adult in Bujumbura, Other than the parents who can be contacted in case of an emergency.	
Name:	**Relationship:**
Physical Address:	
P. O. Box	**Telephone:**
Cell Phone:	**Email Address:**
Name:	**Relationship:**
Physical address:	
P. O. Box	**Telephone:**
Cell Phone:	**Email address:**

Is there any health condition that the school should be aware of which could require **Emergency Action** or place any limitations on your child's physical activity (eg. seizures, asthma, allergy, diabetes, heart problems, etc.)? If yes, please explain:

Is your child on daily or long-term medication? If yes, which medication:
Dosage: **Time/Frequency required:**

Has your child received all childhood vaccinations**? (Please attach immunization records)**

Is your child covered by health insurance?

Insurance provider: _____ Policy #: _____

1. I give my permission for confidential and discreet use of the medical evaluation completed by the physician to meet my child's health and educational needs at school.
2. I give my permission to administer treatment and/or over-the-counter medication at school to my child if deemed necessary by the school staff.
3. I give my permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified.
4. I will keep the health office informed of any change in my child's health and/or medication at all times.
5. List any medical treatments you **DO NOT want your child to receive**:

Father Signature _____ **Date (D/M/YY)** _____

Mother Signature_____**Date (D/M/YY)** _____

PART II: Health Evaluation (To be completed by a physician)

Student Name:					
Date:	**Height:**	**Weight:**	**Pulse:**	**Blood Pressure**	**Blood Type**
General Comments:					

I confirm that the student named above has had a complete physical examination at my office and has no evident health problems except as noted above.

Physician Name: _____
(Print clearly)

Signature: _____ Date: _____

Phone Number: _____

Medical Facility Stamp: