

General Information

Why is Dalat your choice for your child's education?

How did you learn about Dalat International School?

Please add any comments that will assist us to better understand your child as they begin at Dalat International School.

Please read this page before signing

STATEMENT OF FAITH

We believe in God the Father, Son and Holy Spirit; in the verbal inspiration of the Holy Scriptures as originally given; in the substitutionary atonement of the Lord Jesus Christ and the eternal salvation of all who believe in Him and the eternal punishment of all who reject Him.

APPLICABLE WHEN UNDER SCHOOL JURISDICTION

- If, in the opinion of a properly licensed and practicing physician, our child needs medical or surgical services which require our consent before being supplied, and we cannot be reached, we hereby authorize, appoint, and empower the director or his/her designee to furnish on our behalf such written or oral authorization as may be so required. Further, we release the director or his/her designee and Dalat International School from any liability which might arise from giving of such authorization, it being our desire that our child be furnished with such surgical services as soon as reasonably possible after the need arises.
- We give permission for our child to take part in all school activities, including sports and school sponsored trips away from the school premises. We undertake to immediately inform Dalat International School of any change in our child's medical condition. We absolve Dalat International School from all liabilities arising out of any injury at school, during any school dorm activity, save for gross negligence on the part of Dalat International School, or because of any previous medical condition.
- We give permission for our child to receive academic and/or personal counseling by a counselor at Dalat International School. As parents, we will be provided with necessary and relevant information regarding on-going, long-term counseling as appropriate and consistent with the counselor's ethical responsibilities toward the student. Confidentiality does not apply to situations of reported or suspected child abuse, situations in which the student may harm him/herself or others, and/or is in danger of being harmed.

Submission of this application confirms my support for Dalat International School and its policies as stated in the Student and Parent Handbook (available upon request) and Residence Life Handbook. I have read and understand Dalat's Statement of Faith. I agree to withdraw my child when I feel I can no longer support these policies.

To the best of our knowledge, all information on this application is correct.

Parent/Guardian Signature Date DD / MM / YY

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Please return the completed application to:

**Admissions
Dalat International School
Tanjung Bunga, 11200, Penang
Malaysia**

**Tel: (60) 4-899-2105
Fax: (60) 4-890-2141
E-mail: admissions@dalat.org**



STUDENT HEALTH FORM

STUDENT NAME: _____ SEX: _____ DATE OF BIRTH: _____ GRADE: _____

- 1. Is your child presently under a physician's care for any reason? _____ If yes, explain: _____
- 2. Has your child had any INJURY or SURGERY? Please check appropriate boxes and explain:

- | | | | |
|--|----------------------------------|--------------------------------|---|
| <input type="checkbox"/> Head (concussion) | <input type="checkbox"/> Wrist | <input type="checkbox"/> Foot | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Hands | <input type="checkbox"/> Toes | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Fingers | <input type="checkbox"/> Spine | <input type="checkbox"/> Dislocations |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Leg | <input type="checkbox"/> Neck | <input type="checkbox"/> Muscle strains |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> Back <input type="checkbox"/> Ligament strains |
| <input type="checkbox"/> Teeth | <input type="checkbox"/> Knee | <input type="checkbox"/> Arms | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Jaw | <input type="checkbox"/> Ankle | <input type="checkbox"/> Chest | <input type="checkbox"/> Ostomyeletis |

- 3. Does your child have any history of the following CONDITIONS? Please check appropriate boxes:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Genitalia Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Persistent Nose Bleeds |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Stomach (ulcer, etc.) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Consistent Cramping |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Migraine Headaches |

- 4. Is your child currently taking any kind of medication? Yes No If yes, please explain: _____
Instructions for medication: _____

- 5. Has your child taken any medication for emotional/behavioral problems such as Ritalin for ADD/ADHD, Prozac for depression, Xanax for anxiety, etc.? _____ If yes, explain circumstances: _____

- 6. Does your child have a history of emotional/behavioral problems? _____

- 7. List childhood diseases (e.g. chicken pox): _____

- 8. Is your child allergic to any food or medication? Yes No If yes, name food/medication and explain reaction: _____

- 9. Is your child allergic to bee stings? Yes No If yes, explain reaction: _____

- 10. Does your child have any problem that limits his/her participation in athletics? Yes No
If yes, explain: _____

- 11. Does your child have a hearing problem? Yes No If yes, does he/she wear a hearing aid? Yes No

- 12. Does your child have trouble seeing? Yes No If yes, does your child wear glasses or contacts? Yes No

- 13. Blood type (if known): _____

IMMUNIZATION RECORD	DATE – D/M/Y	DATE – D/M/Y	DATE – D/M/Y	DATE – D/M/Y	DATE – D/M/Y
Diphtheria/Tetanus Pertussis					
Polio					
Measles/Mumps/Rubella					
BCG Skin Test (TB)					
Hepatitis B					
Hepatitis A					
Japanese Encephalitis					
Typhoid					
Chicken Pox					
Small Pox					
Yellow Fever					
Influenza					
Tetanus					
Gamma Globulin					
Other					

Signature of Parent/Guardian: _____ Date: _____



PHYSICAL EVALUATION

TO BE COMPLETED BY A PHYSICIAN

Name: _____	Date of birth: _____
Grade: _____	Height: _____
Weight: _____	Pulse: _____
BP: _____ / _____	
Vision: R 20/ _____	L 20/ _____
Corrected: Y / N	Hearing: _____
Urinalysis: _____	

PHYSICAL EXAM

PHYSICAL EXAM			
Eyes/Ears/Nose/Throat		Neck	
Lymph Nodes		Back	
Heart		Shoulder/Arm	
Pulse		Elbow/forearm	
Lungs		Wrist/hand	
Abdomen		Hip/thigh	
Genitalia (males only)		Knee	
Skin		Leg/ankle/feet	

Explain abnormal findings: _____

Cleared for softball, swimming, soccer, volleyball, track, basketball, tennis, badminton, other:

Cleared after completing evaluation/rehabilitation for:

Not cleared for: _____ Reason: _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____