NJIS
NORTH JAKARTA INTERCULTURAL SCHOOL

# Student Health Card

| Current Photo | School year | Grade | Age |
|---|---|---|---|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

This card must be completed and on file in the Clinic on the date the student enters school. The school must be notified of guardianship any time the parents leave Jakarta. Please PRINT the information as requested below.

## Student information

Name (Surname/ First name/ Middle name): _____

Date of Birth (Day/ Month/ Year): _____

Nationality: _____

Language/s spoken: _____

Drug allergies: _____

## Parents' information

Name of Father: _____

Name of Mother: _____

Home address: _____

Home phone number: _____

Office address: _____

Office phone number: _____

**If I cannot be reached, please try:**

Name: _____

Phone number: _____

Relation: _____

Regulation of the **Minister of Health of the Republic of Indonesia number 12 of 2017** on Immunization Implementation.

General provisions of Pasal 1 in the Ministerial Regulation:

1. Immunization is an effort to cause / enhance a person's immunity actively to a disease so that when one day exposed to the disease will not be sick or just experience minor illness.
2. Vaccines are biological products containing antigens in the form of dead or living attenuated microorganisms, intact or part of them, or in the form of toxin microorganisms that have been processed into toxoids or recombinant proteins, added to other substances, administered to a person will induce immunity Active against certain diseases.
3. Immunization program is mandatory for everyone in the comunity in order to protect the surrounding community from disease that can be prevented by immunization.
   Immunization programs consist of :
   **A. Routine immunization**
   Is carried out continuosly. Routine immunization consists of basic immunization. Basic immunization as referred to in Pasal 5 paragaph (2) is given to infants before the age of 1 (one) year, which consist of:

| **Hepatitis B** | **BCG** | **Oral polio** | **DPT (Diphteria, Pertussis, Tetanus** |
|---|---|---|---|
| Date : | Date : | Date : | Date : |

| ***Haemophilus influenza type B* (Hib)** | **Measles** |
|---|---|
| Date : | Date : |

**B. Immunization of choice**
Is an immunization that can be given to a person in accordance with his needs in order to protect the concerned from certain diseases. The immunization of choice may be immune to the disease :

| **Pneumococcus** | **Influenza** | **Chicken pox (varicella)** | **Mumps** |
|---|---|---|---|
| Date : | Date : | Date : | Date : |

| **Rubella** | **Thyphoid fever** | **Hepatitis A** | **HPV(*Human papillovirus for* girls*)*** |
|---|---|---|---|
| Date : | Date : | Date : | Date : |

| ***Japanese Encephalitis*** | **Herpes Zoster** | **Dengue fever** |
|---|---|---|
| Date : | Date : | Date : |

If your child on medication? (Please circle) Yes No

If YES, does your child take it himself? (Please circle) Yes No

Please list the name of the medication and frequency:

_____

_____

Does your child wear glasses/contact lenses? (Please circle) Yes No

**History of disease ever experienced (Mark * and specify the date)**

☐ Chicken pox (varicella) ☐ Pertusis ☐ Congenital anomalies

☐ Dipheteria ☐ Typhoid Fever ☐ Diabetes

☐ Measles ☐ Mumps ☐ Tuberculosis

☐ Enteritis (Diarrhea) ☐ Bronchopneumonia

☐ DHF (Dengue hemorrhagic fever) ☐ Asthma

Others: _____

**THE FOLLOWING HEALTH CONDITIONS CAN BE A CONCERN. PLEASE CIRCLE ANY THAT APPLIES.**

| | | |
|---|---|---|
| Allergic to insect stings. | YES | No |
| Convulsion/Epilepsy | YES | NO |
| Recurring ear infection | YES | NO |
| Hearing difficulties | YES | NO |
| Frequent headaches | YES | NO |
| Heart problem | YES | NO |

If yes, please state: _____

| | | |
|---|---|---|
| Kidney/urinary infection | YES | NO |
| Menstrual problems | YES | NO |
| Orthopedic problems | YES | NO |
| Post-operative condition | YES | NO |
| Rheumatic fever | YES | NO |
| Skin problems | YES | NO |

If yes, please state: _____

Visual problems YES NO

Others: _____

Please explain if there is any limitation on physical activity:

_____

_____

I HEREBY GIVE PERMISSION FOR EMERGENCY MEASURES TO BE INITIATED IN CASE OF ACCIDENT OR SUDDEN ILLNESS WITH THE UNDERSTANDING THAT I WILL BE NOTIFIED. I CERTIFY THAT ALL INFORMATION GIVEN ON THIS CARD IS COMPLETE AND CORRECT.

_____ _____

Parent's signature Date

## Record of visits to the nurse

| Date | Notes |
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