American International School Vienna
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MEDICAL FORM A

MEDICAL HISTORY
ONE PER APPLICANT

TO BE COMPLETED BY THE PARENTS/GUARDIANS

All new students and returning students entering Middle or High School must submit completed Medical Forms A & B before (re-)enrolling at AIS Vienna.

Student's name _____

☐ NEW STUDENT ☐ RETURNING STUDENT UPDATE

Grade (entering) _____ School Year _____ / _____

BASIC INFORMATION

My child uses/has the following:

☐ Glasses ☐ Contacts ☐ Eye Patch ☐ Hearing Aid ☐ Other _____

☐ Braces/Dental Prosthetics

MEDICATION PERMISSION

☐ I give permission for my child to receive the following non-prescription medications at school when needed

☐ Paracetamol/Tylenol ☐ Antacid

☐ Ibuprofen ☐ Antihistamine

☐ I give permission for my child to be given Potassium Iodide tablets in case of nuclear emergency.

https://www.sozialministerium.at/dam/jcr:e6efa16a-925d-4c46-ab27-48adeebe10ea/KI-Tabletten%20-%20Kurzinformation_EN%20final.pdf

IMMUNIZATIONS

☐ I have *submitted a copy of my child's immunizations* along with this form (copies can be scanned in or brought to the nurse's office directly) instead of filling out the form below

OR

☐ I have chosen to enter the information regarding my child's immunizations to the best of my knowledge below:

Immunization*	**FIRST**	**SECOND**	**THIRD**	**FOURTH**	**FIFTH**
	Enter Date of Each Immunization				
DPT or Tetanus Pertussis (whooping cough)					
H. influenza B (HiB)					
Polio (IPV/OPV)					
Tdap booster					
MMR (Measles/Mumps/Rubella) Varicella (chicken pox vaccine) MMR + Varicella					
Hepatitis A					
Hepatitis B					
Tick shot / Zecken Impfung (FSME)					
Meningitis C					
MCV_4 (Meningitis ACWY)					
Meningitis B					
PCV - Pneumococcal					
HPV (Human Papillomavirus)					
BCG					
Covid-19					
Other:					
Other:					

☐ I am interested in being notified if there are any additional vaccine recommendations for my child.

*Please note that there are many variations of recommended vaccines and some depend on where you have lived or traveled. This list is merely to provide a place where you can add vaccines. You may have more or less than the list provided. Some vaccines are combined or given individually.

→ Returning Students: please feel free to list only vaccines given since last update or send a copy of your vaccine booklet.

ALLERGIES

Does your child have any allergies? ☐ Yes ☐ No

If yes, to what? _____

How does your child react to allergy? (Rash, hives, trouble breathing, watery eyes, nose problems, etc.)

_____

_____

How do you treat your child's allergy?

_____

_____

COMMUNICABLE DISEASE HISTORY

Please fill out the chart for each illness listed.

	Never Had	Yes (please include number of infections and most recent date of infections)
Chickenpox (Windpocken)		
German measles (Rubella)		
7-day measles (Rubeola)		
Mumps		
Whooping cough (Pertussis)		
Covid-19		

CURRENT HEALTH

	Does not have	Yes (please include details below)
Diabetes		
Seizure disorders		
Depression		
Anxiety		
Asthma		
Recent hospitalization/surgery		
Current medications		

Please give us a full explanation:

_____

_____

_____

☐ This information can be shared, on a need-to-know basis, with teachers and other adults in the school working with my child.

Signature of **PARENTS/GUARDIANS** _____ Date _____