Dear Parents,

The new Health Forms for the upcoming school year are available on the school web page. All students must submit this form every school year.

✓ Returning Students: Go to the Lincoln home page, www.lincoln.edu.ar, then students and select Health & Wellness. Scroll down the page up to Forms, the document will open in a different tab. Should you have any questions please contact the nurse in the Wellness Center.

✓ New Students: Go to the Lincoln home page, www.lincoln.edu.ar. Click on the Admissions tab then select Forms and Fees the Health Form. Should you have any questions please contact Claudia Pacha.

Both forms can be found in Spanish & English.

Instructions for completion

The Health Form has 3 pages:

- Page 1 should be completed and signed by the student’s parents/guardians.
- Page 2 should be completed by a medical doctor licensed in Argentina.
- Page 3 should be completed by a dentist licensed in Argentina.

Note: New students arriving from abroad may submit the health certificate and the dental certificate from a doctor not certified in Argentina. However, they must submit the updated certificates, completed by a doctor licensed in Argentina, within the first month of attendance at Lincoln.

Both pages of the form should be submitted by:

✓ Returning students: August 16th. Students who have not submitted the form by this date will not be allowed to participate in PE, afterschool activities, or any other activities after due date. Completed forms should be submitted to the ES, MS, or HS secretary.

✓ New students: Health Form and medical/dental certificate must be submitted with the admission package (see note above). New students may not begin classes at Lincoln until their medical and dental certificate has been submitted. Completed forms should be submitted to Claudia Pacha.

Should you have any question, do not hesitate to contact us.

Thank you.
C. HEALTH FORM 2016-2017 (To be kept in the student’s file)

Student’s full name: ...............................................................Grade: ........................... Gender:  M(   )  F(   )

Physician/ pediatrician (BA) .............................................. Tel ................................................

Medical Insurance ............................................................ Assoc. No. ......................................

EMERGENCY contacts: List two contacts should you not be available and your child is sick or injured at school

Name.................................................................Relationship..........................................Tel........................................

Name.................................................................Relationship..........................................Tel........................................

STUDENT’S HEALTH HISTORY

1. Check if your child suffers from any of the following health issues. Specify below if a box is checked:

- Dermatologic: eczema, dermatitis, others.
- Cardiac or blood pressure issues, others.
- Metabolic: diabetes, hypothyroidism, others.
- Respiratory: asthma, bronchospasms, sinusitis, others.
- Hearing: frequent ear infections, hearing loss, others.
- Visual: dry eyes, near/farsighted, others.
- Digestive: frequent stomach pain, constipation, others.
- Motor skills: paralysis, locomotion difficulties, others.
- Allergies: foods, seasonal, medications, others.
- Cognitive: ADD, dyslexia, others.
- Frequent headaches.
- Other: _______________________

Details of conditions checked above:
...........................................................................................................................
...........................................................................................................................

2. Does your child take any medication daily or occasionally?  No (   ) Yes (   ) If yes, please specify.

Diagnosis: .......................................................... Medication: .............................................. Dosage: .................................

NOTE: The Nurse of Asociacion Escuelas Lincoln does not prescribe or supply medication to students. If your child needs to take any medication during the school day, please send the medication together with a medical prescription to the clinic. Clearly state the drug’s dosage and schedule. If your child becomes ill outside of school hours, your private physician should be contacted.

3. Attach “Certificado Médico de Buena Salud” (2nd page). All students must submit this certificate, regardless of their involvement in Physical Activity. Students cannot participate in PE until this certificate is provided.

4. Attach “Dental Health Certificate” (3rd page). All students must submit this certificate. Students cannot participate in PE until this certificate is provided.

5. Immunization Records: Attach vaccination records in Spanish or English. A translation should be provided if the document is in another language.

In the case that your child has an accident/injury on campus, first aid will be immediately administered and you will be contacted. If we are unable to reach you or any of your emergency contacts by phone, the school will continue with appropriate emergency medical care.

By signing below, I authorize the school officials to take whatever action is considered necessary, in their judgment, for the health of my child.

PARENT/ GUARDIAN NAME.................................. DNI................................ Signature.................................Tel..............................

PARENT/ GUARDIAN NAME.................................. DNI................................ Signature.................................Tel..............................
CERTIFICADO MEDICO DE BUENA SALUD / MEDICAL HEALTH CERTIFICATE

Fecha / Date ...........................................

Certifico que ........................................................................................................... de .......... años de edad, ha sido examinado clínicamente y se encuentra en el día de la fecha en buen estado de salud para poder realizar actividades escolares físicas, recreativas y deportivas, que correspondan a su edad, sexo, grado de maduración y desarrollo. / I hereby certify that (student’s name) of (age) years old has been medically examined and is currently in good health to perform school activities, physical, recreational and sports according to his age and growth development.

OBSERVACIONES / OBSERVATIONS: ........................................................................

__________________________________
Firma y Sello del Medico / Doctor’s signature and seal

RECOMENDACIONES
El objetivo de este examen clínico es detectar factores de riego y patologías específicas según sexo y edad. El mismo debería incluir:

- Interrogatorio que incluya antecedentes familiares, hábitos e inmunizaciones
- Examen físico que incluya medidas antropométricas (peso, talla), examen cardiovascular (auscultación, toma de tensión arterial, palpación de pulsos periféricos, etc.) aparato respiratorio (auscultación, frecuencia respiratoria, salud bucal, etc.), aparato osteomioarticular (postura, desviaciones de columna, etc.), abdomen (descartar organomegalía, hernias, etc.), sistema nervioso (pruebas de marcha, equilibrio y coordinación, agudeza visual y auditiva, etc.)

Los estudios complementarios se realizaran según criterio medico.

RECOMMENDATIONS
The medical health examination aim is to detect risk factors and potential diseases according to age and gender. It should include the following elements:

- General assessment concerning health history, vaccination and health habits
- Physical examination which includes anthropometric measure (weight, height), cardiovascular examination (auscultation, blood pressure, palpation peripheral pulses, etc.) respiratory system (auscultation, respiratory rate, dental health, etc.), musculoskeletal system (posture, vertebral column deviations, etc.), abdomen (discard organomegaly, hernias, etc.), neurological system (motor function and coordination, visual and hearing acuity, etc.)

Further examination will be done according to medical judgment.
Para ser completado por el dentista / To be completed by the dentist:

---

CERTIFICADO BUCODENTAL / DENTAL HEALTH CERTIFICATE

Fecha / Date……………………………………

Certifico que…………………………………………………………………………………………… de...........años de edad, presenta estado bucal: BUENO ☐ REGULAR ☐ MALO ☐

Se expide el presente certificado a pedido del interesado para ser presentado ante las autoridades que lo requieran. I hereby certify that (student’s name) of (age) years old has been medically examined and is currently in a state of good dental health. This certificate is issued to be submitted to the authorities that request it.

OBSERVACIONES/ OBSERVATIONS: …………………………………………………………………………………

____________________________
Firma y Sello del Médico/ Doctor’s signature and seal