MANOROM INTERNATIONAL CHRISTIAN SCHOOL

Physical Examination Report (New Student)

A registered Medical Practitioner must complete this form

The examination should be completed no more than 6 months prior to commencement at MICS and submitted to MICS Office or send by email to mics.ac.th@gmail.com.

Academic Year Student commencing MICS ☐ 2018-2019 ☐ 2019-2020

Student Family Name: ___________________________ Given Names: _________________________

Date of Birth: ___________________________________ (DD/MM/YYYY) Gender: ☐ Male ☐ Female

Grade Level at MICS (at start date): _________________

1. Current Health Issues (include medications and allergies):

____

____

2. Health Assessment

Weight: _________________ Units: lbs. or kg Height: _____________________ Units: cm. or feet/inch

Pulse____________________ Blood Pressure________/_________

3. Physical Examination

Medical Appearance	Normal	Abnormal (referred for evaluation or treatment)
Eyes, ears, nose, throat		
Lymph Nodes		
Lungs		
Heart (sound/murmur)		
Peripheral Pulses (nature)		
Abdomen		
Skin		
Musculoskeletal: Head & Neck		
Musculoskeletal: Back (to include scoliosis screening)		
Extremities (to include arms, legs, elbows, knees, hips and ankles)		

4. Cardiac Evaluation For students entering Grades 7-12. ECG result (please attach a copy of the ECG):

____

____

If ECG is Abnormal, please refer the student to a Pediatric Cardiologist for further evaluation and consultation (this may include Echocardiogram or Stress Test, for example). Please indicate any further follow up that is required.

Student Last (Family) Name: ______________________ Given Names:____________________________

5. Hearing Screening

Screened at 20dB: Indicate Pass (P) or Refer (R) in each box:

Ears	1000	2000	4000	6000
Right				
Left				

☐ Refer to Audiologist ☐ Permanent Hearing Loss

Note:

____

____

6. Vision Screening: Corrective lenses or glasses? ☐ Yes ☐ No Color Deficiency Test: ☐ Pass ☐ Fail

Distance	Left	Right	Both
	20/	20/	20/

☐ Pass ☐ Refer to an eye doctor

Note:

____

____

7. Summary of Findings (Check one)

☐ Well child; no conditions of concern have been found or identified. The child is cleared to participate in sports, athletics and school activities.

☐ Condition identified and the child is not cleared to participate in school sports, athletics and activities (please explain here including any restrictions and follow up required):

____

____

____

8. Certification Signature of Medical Provider: __________________________ Date: ____________________

Name of Medical Provider: ____

Qualifications: ____

Official Stamp:

MANOROM INTERNATIONAL CHRISTIAN SCHOOL

Tuberculosis Screening Form (New Student)

Student Family Name: ______________________________ Given Names: ______________________________

Date of Birth (DD/MM/YYYY): _______________________ Grade Level at MICS (at start date): ___________

All new students are required to have a negative screen for Tuberculosis. The screening test done should be discussed with physician to determine the most appropriate screening test for the student. Only ONE of the following tests must be done (not more than 6 months prior to enrollment):

1. Mantoux Skin test ☐ Positive ☐ Negative Date (DD/MM/YYYY): ___________________

Induration in mm: ________________________________

OR

2. Tuberculosis QuantiFERON test ☐ Positive ☐ Negative Date (DD/MM/YYYY): ___________________

OR

3. Chest X-ray ☐ Positive ☐ Negative Date (DD/MM/YYYY): ___________________

Result: ____

If the screening test is positive or suggestive of Tuberculosis, the student must see and Infectious Diseases Physician and provide a medical certificate stating they do not have active Tuberculosis and are not contagious to others. Please also indicate if they have commenced treatment for Tuberculosis.

____

____

Certification (Please do not certify until results are available)

I certify that the above named student does not have active Tuberculosis and is not contagious to others.

Signature of Medical Practitioner: _______________________________ Date (DD/MM/YYYY): _______________

Name of Medical Practitioner: ____

Qualifications: ____

Official Stamp:

MANOROM INTERNATIONAL CHRISTIAN SCHOOL

Certification of Immunization (New Student)

Student Family Name: ______________________________ Given Names: __________________________

Date of Birth (DD/MM/YYYY): ___________________ Grade Level at MICS (at start date): ____________

All students are required to have age appropriate vaccinations unless there is a MEDICAL CONTRAINDICATION for a given vaccine. In this circumstance a medical certificate is required stating reason vaccine was not given. The student will be excluded from school if there is an outbreak of the disease they are not vaccinated against in the community.

REQUIRED Immunizations (please specify date in DD/MM/YYYY):

Vaccine	date	date	date	date	date
DTaP (5 doses)					
Tdap (1 dose at 10-12 years)					
IPV/OPV (4 doses)					
MMR/MMRV (2 doses)					

If MMR/MMRV vaccines were not given students must have received individual measles, mumps and rubella vaccination. Please provide vaccination and dates:

____

____

OPTIONAL Immunizations:

Vaccine	date	date	date
Hep A			
Hep B (3 doses)			
Varicella (if MMRV not given) (2 doses)			
Meningococcal			
Japanese Encephalitis (2 doses)			
Rabies (3 doses)			
HPV (2-3 doses)			
Annual Influenza (last 3 doses)			

I certify that ____ (student's name) is age appropriately immunized and has had the required immunizations above as required by MICS.

Signature of Medical Practitioner: _________________________ Date (DD/MM/YYYY): ______________

Name of Medical Practitioner: ___________________________________

Qualifications: ____

Official Stamp:

MANOROM INTERNATIONAL CHRISTIAN SCHOOL

Nurse Medication and Emergency Treatment Consent Form

Parents to complete this form

Student Family Name: ______________________________ Given Names: _________________________

Date of Birth (DD/MM/YYYY): _______________________ Grade Level at MICS (at start date): _________

The School Health Clinic provides some over the counter medications that your child may benefit from for certain presentations to the clinic. We will only provide these medications with parental consent. Please indicate whether you give consent for the nurse to administer the following:

Medication:	Use	Yes	No	Call Parent
Acetaminophen/Paracetamol	Pain, fever			
Ibuprofen	Pain, fever			
Decongestant (like Dimetapp)	Nasal and sinus congestion			
Antacid (like Tums)	Stomach upset			
Antihistamine	Allergy			

I/We consent for the above named student to be given over the counter medications as outlined above. I/We undertake that I/we have given ISB authority to administer this medication on my behalf and accept full responsibility for the same in the event that my child has any adverse reaction to this medication, provided that the medication was administered in accordance with the instructions on the packaging. I/We give consent for emergency medical care to be provided to my child (on campus and during off campus ISB activities) with the understanding that I/we will be contacted as soon as possible. (Only one parent is required to sign; both may sign if you prefer.)

Signed: _____________________________(Parent) Signed: ______________________________(Parent)

Name: ___________________________________ Name: _____________________________________

Telephone Number: ________________________ Telephone Number: ___________________________

Date (DD/MM/YYYY): ______________________ Date (DD/MM/YYYY): __________________________