

**INTERNATIONAL COMMUNITY SCHOOL
PHYSICIAN'S EXAMINATION FORM***

Student's Name: _____ Grade: _____ Birth Date: _____
 Passport, FIN, or NRIC Number: _____ Country: _____
 Father's Name: _____ Hand Phone: _____
 Mother's Name: _____ Hand Phone: _____
 Emergency Contact: _____ Hand Phone: _____
 Family Doctor: _____ Phone: _____

TO BE COMPLETED BY A GENERAL PHYSICIAN OR FAMILY DOCTOR

Height: _____ Weight: _____ B/P: _____ Pulse: _____

Current Medication	Dosage	Purpose

	Normal	Abnormal		Normal	Abnormal
Head			Abdomen		
Eyes			Skin		
ENT			Extremities		
Dental			Spine		
Chest					

	Yes	No		Yes	No
Chronic/recurrent illness			Concussion		
Hospitalizations			Asthma		
Surgery			Problems with bladder/kidneys		
Injury treated by physician			Problems with heart/murmurs		
Organs missing			Problems with spleen/liver		
Heat exhaustion/stroke			Hernias/GI problems		
Dizziness/fainting/headaches			Recurrent skin problems		
Convulsions/fits			Bone/joint injury		
Wear glasses/contacts			Sprain/dislocation		
Dental caps/bridges/braces/plates			Bone fractures		
Diabetes			Hearing problems		
Cancer			Vision problems		
Seizures/convulsions			Depression		
Kidney disease/injury			TB/PPD (+ or -)		

Explanation:

Physician Signature and Stamp

Date

***In case of emergency, this form is used to give your child the best medical care possible.**

TO BE COMPLETED BY PARENTS

Allergy: _____ Type of Reaction: _____

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Does any condition affect or limit your child's participation in physical education classes, sports, or school trips? Yes No If yes, please explain: _____

PERMISSION FOR GIVING MEDICATION FOR MINOR COMPLAINTS

I give permission for my child to be given Panadol (paracetamol) for minor aches, menstrual cramps, and headaches. Yes No

PERMISSION FOR EMERGENCY TREATMENT

In the event that I cannot be reached in an emergency, I give permission for my child to receive medical treatment, including transport to the most accessible hospital, as deemed necessary by school authorities. Yes No

IMMUNIZATION HISTORY

Please fill in the dates of immunization.

MANDATORY						
Diphtheria						
Tetanus						
Polio						
Measles						
Hepatitis B						
RECOMMENDED						
Pertussis						
Mumps						
Rubella						
Hepatitis A						
Typhoid						
Chicken Pox						
BCG						

It is the responsibility of the parent/guardian to notify the school in writing of any changes to the information given in this form.

Parent/Guardian Printed Name

Signature

Date