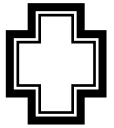




# STUDENT MEDICAL EXAMINATION FORM



Niva International School (Form AD-3)

18 Soi Pho Kaew Yaek 9, Klongchan, Bangkok, Bangkok 10240 Thailand Tel# 02-9484607 ext 102

Please attach a recent photo

Entering grade: \_\_\_\_\_ Admission date: \_\_\_\_\_ Registration no. \_\_\_\_\_

PLEASE PRINT LEGIBLY IN BLOCK LETTERS

Name of Student (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Nick name: \_\_\_\_\_

Gender/Sex:  Male  Female Birth date: Day \_\_\_\_\_ Mo \_\_\_\_\_ Yr \_\_\_\_\_ Nationality: \_\_\_\_\_

Parent's Name: Father (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Mother (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Home Address in Thailand: \_\_\_\_\_ Home Tel: \_\_\_\_\_

### Medical History:

1. Significant illness, accidents, operations, congenital defects, family history, etc. \_\_\_\_\_
2. Significant factors in home situation relating: well-being and academic performances \_\_\_\_\_

**To the private physician:** In order that the student's program can be adjusted to his physical condition, and in order that sound health counseling can be given him, it is necessary for the school to have a report of his health examination. This report will be held in confidence and used only for the protection and aid of the student in his education. Thank you.

3. Are there abnormalities of the following systems? If yes, describe fully. Use additional sheet if necessary.

a. Head, Ears, Nose, or Throat	Yes	No	h. Height _____ Weight _____ BMI _____
b. Hearing R _____ L _____	Yes	No	Any significant weight changes in the last year? _____ Yes No
c. Eyes: Vision R _____ L _____	Yes	No	i. Is there any serious physical defect? _____ Yes No
d. Cardiovascular System	Yes	No	j. Is the student now under treatment for any medical or emotional condition? _____ Yes No
Blood Pressure _____ mmHg			k. Recommended for physical activity (Phys. Ed., Intramurals, etc.) <input type="radio"/> Unlimited <input type="radio"/> Limited Explain _____
Pulse Rate _____ Respiratory Rate _____			l. Recommended class load and labor load <input type="radio"/> Restricted <input type="radio"/> Unrestricted
e. Gastrointestinal System	Yes	No	m. Allergies: _____ (Medication, food, and/or other)
f. Genitourinary System	Yes	No	n. General Comments: _____
g. Musculoskeletal System	Yes	No	
h. Metabolic Endocrine System	Yes	No	

4. These immunizations are required and must be completed in full and signed by physician before student can be accepted. An official record of childhood and current immunizations must accompany school file. Please attach to this form.

History of Immunizations	Day/ Month/ Year
<b>BCG (TB Vaccine), if given</b>	
	No. 1 _____
Diphtheria/	No. 2 _____
Pertussis/	No. 3 _____
Tetanus	No. 4 _____
(DPT) or (DT)	No. 5 _____
	No. 6 _____
	No. 1 _____
Polio (OPV) and/or	No. 2 _____
IPV	No. 3 _____
	No. 4 _____
	No. 5 _____
	No. 1 _____
Measles (Rubella,	No. 2 _____
Rubeola -German)	
	No. 1 _____
Mumps	No. 2 _____
	No. 1 _____
Varicella (chicken pox)	No. 2 _____
Hepatitis A _____	
B _____	
Japanese Encephalitis _____	
Others: _____	

5. Tuberculin skin test \_\_\_\_\_ Chest X-Ray \_\_\_\_\_

6. PLEASE CONDUCT THESE TESTS (if appropriate) AND ATTACH INFORMATION ABOUT TESTS GIVEN AND THE RESULTS

	Required		If there is evidence of the following conditions please test for and attach information
Neuropsychiatric	YES	NO	
Learning Disabilities	YES	NO	
Dyslexia	YES	NO	
Attention Deficit Disorder (ADHD)	YES	NO	
Hyperactivity	YES	NO	
Underachiever Characteristics	YES	NO	

Hospital Stamp

Physician's Name & Signature

Date of Examination (Day/Month/Year)

I hereby certify that the above information is true and was tested to the best of my ability.