STUDENT MEDICAL EXAMINATION FORM

Niva International School **(Form AD-3)**

18 Soi Pho Kaew Yaek 9, Klongchan, Bangkapi, 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
b. Hearing R _____L _____	**Yes**	**No**
c Eyes : Vision R_____L_____	**Yes**	**No**
d. Cardiovascular System	Yes	No
Blood Pressure _____mmHg		
Pulse Rate _____Respiratory Rate _____		
e. Gastrointestinal System	Yes	No
f. Genitourinary System	Yes	No
g. Musculoskeletal System	Yes	No
h. Metabolic Endocrine System	Yes	No

h. **Height _____Weight _____ BMI _____**
Any significant weight changes in the last year? _____ Yes No

i. Is there any serious physical defect? **Yes No**

j. Is the student now under treatment for any medical or emotional condition?
_____ _____ **Yes No**

k. Recommended for physical activity (Phys. Ed., Intramurals, etc.)
○**Unlimited** ○**Limited Explain** _____

l. Recommended class load and labor load ○**Restricted** ○**Unrestricted**

m. Allergies: _____
(Medication, food, and /or other)

n. General Comments: _____

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**
BCG (TB Vaccine), if given	
Diptheria/ Pertussis/ Tetanus (DPT) or (DT)	No. 1 _____ No. 2 _____ No. 3 _____ No. 4 _____ No. 5 _____ No. 6 _____
Polio (OPV) and/or IPV	No. 1 _____ No. 2 _____ No. 3 _____ No. 4 _____ No. 5 _____
Measles (Rubella, Rubeola -German)	No. 1 _____ No. 2 _____
Mumps	No. 1 _____ No. 2 _____
Varicella (chicken pox)	No. 1 _____ 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.