International School Bangkok

Instructions for Completion of New Students Medical Package

All new students must complete the New Students Medical Package.
This should be completed no more than 6 months **BEFORE** commencement date at ISB.

Please see the following attached forms which are in the medical package:

1. **Physical Examination Report (New Student)**
   This form must be completed by a licensed Medical Practitioner.
2. **Tuberculosis Screening Form (New Student)**
   This form must be completed by a licensed Medical Practitioner.
3. **Certificate of Immunization**
   This form must be completed by a licensed Medical Practitioner.
4. **Nurse Medication and Emergency Treatment Consent Form**
   This form must be filled out by one or both parents.

Please note:

- These forms must be submitted to the ISB Admissions Office or emailed to admissions@isb.ac.th.
- The registered Medical Practitioner does not need to be Thailand based.
- Please ensure all current health issues (physical/social/emotional/behavioural) are discussed with the Medical Practitioner. This information will be kept in the student's health records and will ONLY be available to staff members directly involved with the student's education and care.
- Incomplete medical packages will not be accepted. **ALL** forms must be completed and submitted at the same time.
- If students have anaphylaxis, insulin dependent diabetes or severe/poorly controlled asthma, care plans for these conditions MUST be submitted with the medical package. These forms are available from the ISB Health Clinic (email nurse@isb.ac.th) or the ISB website under Health Services.
- If a student requires medication to be given on a regular basis a Prescription Medication Consent form must be filled out by the treating medical practitioner and signed by the parents. This form is available from the ISB Health Clinic (email nurse@isb.ac.th) or the ISB website under Health Services.

International School Bangkok

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 ISB and submitted to the ISB Admissions Office or sent by email to admissions@isb.ac.th **BEFORE** the student can be authorized to start school.
Any queries regarding this Physical Examination Report please email nurse@isb.ac.th or call +662-960-4109

Academic Year Student commencing ISB ☐ 2019/20 ☐ 2020/21

Student Family Name: ______________________________ Given Names: __________________________________

Date of Birth: _____________ (dd/mm/yyyy) Gender: ☐ M ☐ F Grade Level at ISB (at start date): _________

1. Current Health Issues (include medication and allergies): ____

____

____

2. Health Assessment

Weight: _______________ Units: lbs. or Kg Height: ______________ units: cm or feet/inches BMI:_________

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 6-12.

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.

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International School Bangkok

Student Last (Family) Name: ______________________________ Given Names: ________________________________

5. Hearing Screening

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

	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: ____

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7. Summary of Findings (Select one)

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

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

____

____

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7. Certification

Signature of Medical Provider: ____________________________________ Date: ___________________________

Name of Medical Provider: ______________________________________

Qualifications: ____

Official Stamp:

International School Bangkok

Tuberculosis Screening Form (New Student)

Student Family Name: ______________________________ Given Names: ______________________________

Date of Birth (dd/mm/yyyy): ________________ Grade Level at ISB (at start date): ____________

All new students are required to have a negative screen for Tuberculosis and **results submitted**.
The test done should be discussed with the 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/yy): __________

   Induration in mm: __________________

OR

2. Tuberculosis QuantiFERON test ▫ Positive ▫ Negative Date (dd/mm/yy): __________

OR

3. Chest X-ray ▫ Positive ▫ Negative Date (dd/mm/yy): __________

   Result: ____

If the screening test is positive or suggestive of Tuberculosis, the student must see an 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.

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____

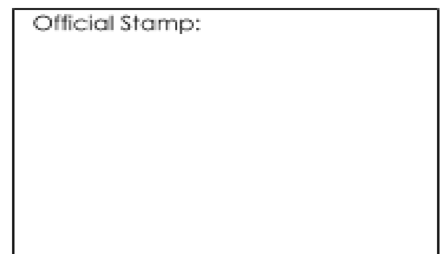
Certification (Please do not certify until results are available)

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: ________________________



International School Bangkok

Certificate of Immunization

Student Family Name: ________________________________ Given Names: ______________________________

Date of Birth (dd/mm/yyyy): _______________ Grade Level at ISB (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):

	Date	Date	Date	Date	Date
DTaP (5 doses)					
Tdap (1 dose at 10-12 years)					
IPV/OPV (4 doses. Last dose must be given at 4 years or older)					
MMR/MMRV (2 doses)					

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

I certify that ________________________________ (student's name) is age appropriately immunized and has had the required immunizations above as required by International School Bangkok (ISB).

Signature of Medical Practitioner: ____________________________ Date (dd/mm/yyyy): __________

Name of Medical Practitioner: ______________________________

Qualifications: __________________

Official Stamp:

Nurse Medication and Emergency Treatment Consent Form 2019/20/21

****Parents to complete this form****

Student Family Name: ______________________________ Given Names: ___________________________________

Date of Birth (dd/mm/yyyy): ________________ Grade Level at ISB (at start date): _________________

The School Health Clinic provides some over the counter medication that your child may benefit from for certain presentations to the clinic.

Nurses will assess your child thoroughly and only administer medication with parental consent.

Please indicate whether you give consent for the nurse to administer the

International School Bangkok

following:

Medication:	**Use**	**Yes**	**No**
Tylenol (paracetamol)	Pain, fever relief		
Ibuprofen/nurofen (advil)	Pain, fever relief		
Antihistamine/Decongestant e.g. norfed	Cold and sinus congestion		
Antacid e.g. gaviscon or kremil	Indigestion, heartburn		
Antihistamine e.g. zyrtec	Cold and allergy symptoms		

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 off campus ISB activities with the understanding that I/we will be contacted as soon as possible.

I/We understand that current health issues will be updated in our child's health records and will be available to staff directly involved in our child's education and care.

(Only one parent is required to sign; both may sign if you prefer.)

Signed: __________________________________(Parent)

Name: ___________________________________

Telephone Number: ______________________

Date (dd/mm/yyyy): _____________________

Signed: _______________________________(Parent)

Name: ____________________________________

Telephone Number: _______________________

Date (dd/mm/yyyy): _______________________