International School Bangkok

Instructions for Completion of Returning Students Medical Package

The following medical package must be completed by a medical practitioner for returning students entering grades 3, 6, and 9, unless a New Student Medical Package has been submitted in the preceding 6 months.

Medical Test Required	Grade 3	Grade 6	Grade 9
Physical exam	X	X	X
ECG		X	X
TB Screeing	X	X	X
Hearing & Vision	X	X	X
Immunization Review	X	X	X
All must also submit the **Medication and Emergency Treatment Consent Form**.			

Please note:

- These forms should be submitted to the ISB Health Centre by July 15th 2021.
- **Incomplete medical packages will not be accepted. ALL forms must be filled out and submitted at the same time.**
- Completed forms can be scanned and emailed to nurse@isb.ac.th
- Please ensure all current health issues (physical/social/emotional/behavioural) are discussed with a 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 students education and care.
- If a student has anaphylaxis, Type 1 Diabetes, or moderate to severe asthma, Care Plans for these conditions **MUST** be submitted with the medical package. These forms are available on the ISB website under Health Services.
- If a student requires medication to be given on a daily basis such as ritalin at lunchtime, a Long Term Prescription Medication Consent form MUST be filled out by the treating medical practitioner and parents. This form is also available on the ISB website under Health Services.
- We encourage all families regardless of grade level to undergo yearly history and physical assessments and consult with your physician with any changes to your child's health.

Please call 02-960-4109 or email nurse@isb.ac.th if you have any questions about these forms as we are happy to help.

International School Bangkok

Physical Examination Report (Returning Grade 3, 6, and 9 Students)

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 Admissions Office **BEFORE** the student can be authorized to start school. Scanned copies are permissible. Any queries regarding this Physical Examination Report please email nurse@isb.ac.th or call +662-960-4109

Please complete the information below on behalf of the student:

Family name _____ **DOB** (d/m/y) _____

Given names _____ **Gender** _____

Enrolling in grade _____ **Enrolling in academic year** ❑ 21/22 ❑ 22/23

1. Current health issues *(include medication and allergies)* _____

_____

_____

2. Health assessment

Weight _____ (kg or lbs) Height _____ (cm or ft/in) BMI _____

Pulse _____ Blood Pr. _____

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		
Extremities (to include arms, legs, elbows, knees, hips and ankles)		

International School Bangkok

4. Musculoskeletal Evaluation (Scoliosis screening)- *only required for students entering grades 6-12*

Appearance	Normal	Abnormal (referred for evaluation or treatment)
Torso asymmetry		
Truncal asymmetry		

If 'Abnormal', please list physical activity restrictions: _____

_____

_____

❑ No further referral necessary ❑ Refer to a _____ specialist

5. Cardiac Evaluation - *only required for students entering Grade 6 and Grade 9*

ECG Results *(please attach a copy of the ECG)*: _____

_____

_____

If ECG is abnormal, please refer the student to a Pediatric Cardiologist for further evaluation and consultation. Please indicate above if any further follow up is required.

6. Hearing Screening

Screened at 20db. Please indicate Pass (**P**) or Refer (**R**) in each box

Ear	1000	2000	4000	6000
Right				
Left				

❑ Refer to Audiologist ❑ Permanent hearing loss

Please list any additional information: _____

_____

7. Vision Screening

Correction lenses/glasses? ❑ Yes ❑ No Color deficiency test: ❑ Pass ❑ Fail

Distance	Left eye	Right eye	Both eyes
	20/	20/	20/

❑ Pass ❑ Refer to an eye doctor

Please list any additional information: _____

_____

International School Bangkok

8. 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):**

9. Certification

Name of Medical Provider	Signature	Official Stamp
Qualifications	Date (d/m/y)	

International School Bangkok

Tuberculosis Screening Form (Returning Grade 3, 6, and 9 Students)

Please complete the information below on behalf of the student:

Family name _____ **DOB** (d/m/y) _____

Given names _____ **Enrolling in grade** _____

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*):

TEST 1 - **Mantoux Skin Test**

- ❑ Positive Induration: _____ mm
- ❑ Negative Date (d/m/y): _____

Test 2 - **Tuberculosis QuantiFERON test**

- ❑ Positive
- ❑ Negative Date (d/m/y): _____

Test 3 **- Chest X-ray**

- ❑ Positive Results of test: _____
- ❑ Negative Date (d/m/y): _____

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.

_____

_____

_____

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.

Name of Medical Provider	Signature	Official Stamp
Qualifications	Date (d/m/y)	

International School Bangkok

Immunization Review

Please complete the information below on behalf of the student:

Family name _____ **DOB** (d/m/y) _____

Given names _____ **Enrolling in grade** _____

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 the reason the 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.

Please verify that the student's immunization record meets the requirements in the table below.

Required Vaccines	Number of doses required
DTaP	**5**
Tdap	**1**
IPV/OPV	**4**
MMR/MMRV	**2**
If MMR/MMRV vaccine was not given, students must have received the following immunizations individually:	
Measles	**2**
Mumps	**2**
Rubella	**2**

Certification

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

Name of Medical Provider	Signature	Official Stamp
Qualifications	Date (d/m/y)	

International School Bangkok

Nurse Medication and Emergency Treatment Consent Form

This form is to be completed by the parents/guardians.

Please complete the information below on behalf of your child:

Family name _____ **DOB** (d/m/y) _____

Given names _____ **Enrolling in grade** _____

The school's Health Center 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 following:

Medication	Used for	Consent	
Tylenol (Paracetamol)	Pain, fever relief	❑ Yes	❑ No
Ibuprofen/Nurofen (Advil)	Pain, fever relief	❑ Yes	❑ No
Antihistamine/Decongestant e.g. Norfed	Cold and sinus congestion	❑ Yes	❑ No
Antacid e.g. Gaviscon or Kremil	Indigestion, heartburn	❑ Yes	❑ No
Antihistamine e.g. Zyrtec	Cold and allergy symptoms	❑ Yes	❑ No

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/guardian is required to sign; both may sign if you prefer.)

Parent/Guardian 1

Signed: _____

Name: _____

Phone #: _____

Date (d/m/y): _____

Parent/Guardian 2

Signed: _____

Name: _____

Phone #: _____

Date (d/m/y): _____