MEDICAL EXAMINATION FORM

International School HO CHI MINH CITY
Energized · Engaged · Empowered

Primary Campus
28 Vo Truong Toan St.,
An Phu, Dist. 2, HCMC

Secondary Campus
1 Xuan Thuy St., Thao Dien,
Dist. 2, HCMC

Tel: (84-28) 3898 9100
Fax: (84-28) 3898 9382
Email: admissions@ishcmc.edu.vn

www.ishcmc.com

- This form is required for all applications to International School Ho Chi Minh City (ISHCMC) and must be signed by a parent before a student attends classes or participates in any activities.
- This form must be completed no earlier than six months prior to the start of school. Please see the accompanying information sheet for a list of recommended clinics in Ho Chi Minh City if required.
- ISHCMC reserves the right to withhold a student from classes until this form is completed in full and returned to the admissions office.

PASSPORT PHOTO

Student's name:. . . . . (Family) (First) (Middle)

Date of birth: . . . . . (day/month/year) Sex: □ Male □ Female

PART 1: TO BE FILLED OUT AND SIGNED BY PARENTS

PARENT/GUARDIAN CONTACT

Name: . . . . . Phone: . . . . .

Relationship: . . . . . Email: . . . . .

Name: . . . . . Phone: . . . . .

Relationship: . . . . . Email: . . . . .

Local doctor or health care provider in HCMC: . . . . . Phone: . . . . .

EMERGENCY CONTACT

Name (not parent): . . . . .

Relationship: . . . . . Phone: . . . . .

Medical Insurance: □ Yes □ No

Name: . . . . .

Phone: . . . . . Insurance number: . . . . .

If the student requires medication to be given during school hours please complete a *Request to Administer Medication Form*. All medications along with the form must be submitted to the school clinic. Medications need to be in the original pharmacy/doctor's containers and marked with the student's name, name of drug, dosage, schedule and instructions. All information must be in English. Students are not permitted to carry any medication in their personal belongings while at school.

If the student has significant allergies requiring emergency medications or if the student has a medical diagnosis requiring the nurse's attention, please contact the school to set up an appointment to meet with the School Health Center prior to the student's commencement at ISHCMC.

(If you have no immunization records, please provide results of essential blood tests: Hep A, Hep B, MMR)
Permission to administer Paracetamol: ☐ Yes ☐ No | PE Participation Approved: ☐ Yes ☐ No
Competitive Sports Participation Approved? ☐ Yes ☐ No

Emergency Treatment Authorization: In the event of an emergency, when immediate observation or treatment is deemed necessary in the judgment of the school Health Center staff, I authorize and direct the school authorities to send my child to the medical facility most readily available. If an ambulance is required this will be at the parent's expense.

Parent / Guardian Signature. . . . . Date. . . . . .

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL IN WRITING OF ANY CHANGES TO THE INFORMATION GIVEN IN THIS FORM e.g. changes of address, telephone number, physical condition or medications.
School Clinic *Email: nurse@ishcmc.edu.vn. Phone: +84 28 3898 9100* ***Ext:*** *2105*

PART 2: TO BE FILLED OUT BY A DOCTOR

Student's name: . . . . . .
(Family) *(First)* *(Middle)*

HEALTH HISTORY

Has the student exerienced any of the following in the past? Please mark "X" to indicate Yes or No

	Yes	No
Asthma		
Chronic/recurrent illness		
Hospitalizations/surgery		
Other (ADHD, Autism, etc.)		
Injury treated by physician		
Congenital abnormality		
Heat exhaustion/stroke		
Dizziness/fainting/headaches		
Concussion		
Eyes:related conditions/wears glasses/contacts		
Dental caps/bridges/braces/plates/decay		
Cardiac abnormalities/ heart/murmurs		
Problems with bladder/kidneys		
Skin conditions/ Eczema		
Skeletal (fractures, dislocations/sprains/scoliosis)		

Summary: If you answered Yes to any of the above, please provide details:

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ALLERGIES: . . . .

. . . . . .

Height: . . . . . Weight: . . . . . .

B/P: . . . . . Heart Rate: . . . . . .

Current Medications	Dosage	Purpose

	Normal	Abnormal
Head		
ENT		
Chest		
Abdomen		

Immunization HISTORY

Take your child's immunization record to the Dr appointment to transfer the immunizations onto our ISHCMC Medical Form to ensure that your child has received all of the School Required vaccinations.

School required:	Date	Date	Date	Date	Date	Remarks
DPT (Diphtheria, Pertussis, Tetanus)						
Polio						
Measles						
Mumps						
Rubella						
Hepatitis A						
Hepatitis B						
Haemophylus Influenza (Hib)						
Chicken Pox (Varicella)						
Recommended for Vietnam:	**Date**	**Date**	**Date**	**Date**	**Date**	**Remarks**
Rabies						
BCG (TB)						
Typhoid						
HPV						
Japanese Encephalitis						
Meningococcal						
Pneumococcal						

Doctor Signature/Stamp:. . . . . **Date** . . . . . .

☐ **Immunization current for age, as certified by a doctor.**