INFORMATION ON FILLING OUT MEDICAL EXAMINATION FORM

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

Dear Parents and Doctor,

Thank you for ensuring that all parts of this medical form are complete. There are two parts: **Part 1** by parents, and **Part 2** with your child's doctor. Here are a few notes to make your child's checkup more efficient:

Allergies: It's important to mention all allergic reactions to food or medications to your doctor.

Action Plan: Please provide any relevant information about your child that would help the school clinic staff to respond appropriately in an emergency. This is particularly useful if your child has asthma or allergies.

Vaccinations: Please take your child's immunization record to the Dr appointment and ask the Dr to transcribe each of their vaccinations onto our form **(Part 2)**.

Name	Address	Telephone	Website
Columbia Asia Int. Clinic	8 Alexandre de Rhodes St., Dist. 1	+84 28 3823 8455	www.columbiaasia.com
Family Medical Practice	Diamond Plaza, 34 Le Duan St., Dist. 1 95 Thao Dien St., Dist. 2	+84 28 3822 7848 +84 28 3744 2000	www.vietnammedicalpractice.com
Franco Vietnamese Hospital	6 Nguyen Luong Bang St.,Phu My Hung, Dist. 7	+84 28 5411 3333 Ext.1260	www.fvhospital.com
Raffles Medical	167A Nam Ky Khoi Nghia St., Dist. 3	+84 28 3824 0777	www.rafflesmedical.vn
VinMec Central Park International Hospital	208 Nguyen Huu Canh St., Binh Thanh Dist.	+ 84 28 3622 1166 + 84 28 3622 1188	www.vinmec.com

When you have completed the form please return to admissions department or email a scanned copy. If you have any questions, please contact the ISHCMC Health Center on +84 28 3898 9100 Ext: 2105 or email nurse@ishcmc.edu.vn

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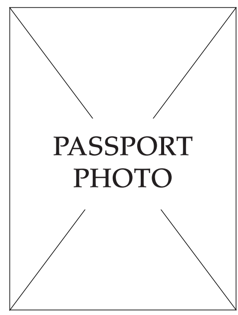
- *This form is required for all applications to International School Ho Chi Minh City (ISHCMC) and must be signed by a parent before a student attends classes or participates in any activities.*
- *This form must be completed no earlier than six months prior to the start of school. Please see the accompanying 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.*



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:

. . . .

. . . .

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.**