

## Student Physical Examination

For Use Beginning: \_\_\_\_\_

File Name: Form

Last Update: 02/2022

Division: All school

Purpose: Doctor completed health form for students

To be completed by a medical doctor within 6 months prior to starting at Concordia. This form is for **all new students and for returning Students before the start of every three-academic year.**

体检表于入学前 6 个月内由医生完成。所有新生须提交此表， 老生每三个学年须提交此表。

**To the Physician: Please make a physical examination of the below-named student and use the codes indicated in marking the conditions.**

致医生：请对以下学生进行体检，并使用所示的代码填写表格。

Student's Name: Last, First, Middle 姓名 \_\_\_\_\_

Date of Birth 生日 \_\_\_\_\_

Gender 性别 \_\_\_\_\_

Grade 年级 \_\_\_\_\_

Height 身高 \_\_\_\_\_ (cm)

Weight 体重 \_\_\_\_\_ (kg)

Pulse 脉搏 \_\_\_\_\_

BP 血压 \_\_\_\_\_

**Code: No Defects – 0; Defects – X; Immediate Attention Desired – XX; Under Treatment – T; Corrected – C**

代码：正常 – 0; 异常 – X; 须立即治疗 – XX; 治疗中 – T; 治愈 – C

Vision 裸眼视力	L	R	Nutrition 营养状况		Muscle Tone 肌张力	
w/glasses 矫正视力(眼镜)	L	R	Scalp/Hair 头皮/头发		Thyroid 甲状腺	
w/contacts 矫正视力(隐形眼镜)	L	R	Heart/Circulation 心脏/循环系统		Lungs/Chest 肺部/胸部	
Color perception 辨色力			Nervous System 神经系统		Lymph 淋巴系统	
Hearing 听力	L	R	Skin 皮肤		Abdomen 腹部	
Ears 耳			Speech 语言能力		Dental 齿科	
Throat 咽			Orthopedic 骨骼		Menses? 月经	Y   N
Nose 鼻			Scoliosis? 脊柱侧弯	Y   N	Other 其他	

Abnormal findings explain 异常情况 \_\_\_\_\_

### Physical Activities: Normal Physical Education Classes, Swimming and Competitive Sports

体育活动：体育课，游泳课和竞技类运动

1. \_\_\_\_\_ Cleared: No restrictions for all activities 活动不受限制

2. \_\_\_\_\_ Not cleared 活动受限, Reason 受限原因: \_\_\_\_\_, Date cleared 受限时长: \_\_\_\_\_

3. \_\_\_\_\_ Cleared with modifications 活动调整, Reason 调整原因: \_\_\_\_\_, Date cleared 调整时长: \_\_\_\_\_

### Allergies: If prescribing an Epi-pen, please prescribe TWO sets. Two Epi-pens to keep at school and two to be kept at home

过敏情况：如果医生开具肾上腺素注射器，请开具至少两组，一组保存在学校，一组保存在家中

1. \_\_\_\_\_ None 无过敏

2. Food 食物过敏 \_\_\_\_\_ Medication 药物过敏 \_\_\_\_\_ Insect 昆虫过敏 \_\_\_\_\_ Environmental 环境过敏 \_\_\_\_\_

3. Symptoms 过敏症状 \_\_\_\_\_

4. Treatment 治疗 \_\_\_\_\_

### Medication: Is this student taking any medication (oral or injection) on a regular basis

药物：该学生是否在常规使用药物

1. \_\_\_\_\_ No 否

2. \_\_\_\_\_ Yes 是, indicate the medication and diagnosis 用药情况和诊断 \_\_\_\_\_

## Tuberculosis questionnaire

### 结核问卷

1. Has the student been close contacts of a person with infectious Tuberculosis disease? \_\_\_\_\_ Yes 是 \_\_\_\_\_ No 否  
学生是否与结核感染者有过密切接触？
2. Does the student have the following symptoms? \_\_\_\_\_ Yes 是 \_\_\_\_\_ No 否  
学生是否有以下症状：
- Persistent cough that lasts 2 weeks or longer 长达2周及以上的咳嗽
  - Pain in the chest 胸痛
  - Coughing up blood or sputum 咯血或血痰

If you answered YES to any of the above questions or have symptoms of TB infection, please show proof of a negative TB screen result. You may either do one of the following: PPD skin test, Chest X-ray, IGRAs (T-spot/QuantiFERON Gold) blood test, enclose the report along with the physical form.

如果学生有上述任一情况，或有疑似肺结核症状，请进行结核菌素试验或胸片或γ干扰素血液检测，并在此体检表格后附上报告。

## Immunization Record

### 疫苗记录

Concordia has a mandatory vaccination and immunization policy, following the CDC immunization schedule. We require student to have up-to-date and/or completed **MMR, DPT, and Polio series** in order to attend school, varicella vaccine is highly recommended. Please fill the vaccine record and ensure your copy has the exact dates the immunization was received. 协和国际根据疾控中心的免疫程序，有相应的疫苗接种要求。学生应完成相应的**麻腮风、百白破和脊髓灰质炎疫苗接种**，以便上学，同时我们强烈建议接种水痘疫苗。请医生填写疫苗记录，并确保您提交的复印件有免疫接种的确切日期。

Name of Vaccination	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
Diphtheria/Pertussis/Tetanus (DPT, DTaP, Tdap) <b>(Required)</b> (2, 4, 6, 15-18 months, 4-6 years old; booster: 11-12 years old)	/ /	/ /	/ /	/ /	/ /	/ /
Polio (Oral / Injection) <b>(Required)</b> (2, 4, 6 -18 months, 4-6 years old)	/ /	/ /	/ /	/ /	/ /	/ /
Measles/Mumps/Rubella (MMR) <b>(Required)</b> (12-15 months, 4-6 years old)	/ /	/ /				
Varicella (Chicken Pox) <b>(Highly Recommended)</b> (12-15 months, 4-6 years old)	/ /	/ /				
COVID vaccine	/ /	/ /	/ /			

Indicate the date of any other immunizations your child has received in the past year:

注明孩子过去一年中接种其他疫苗的日期：

\_\_\_\_\_

Doctor's Name (please use CAPITAL LETTERS) 医生姓名 \_\_\_\_\_ Doctor's Signature 医生签章 \_\_\_\_\_

Doctor's Address and Stamp 医院地址及盖章 \_\_\_\_\_

Date of Examination 检查日期 \_\_\_\_\_ Telephone (Country and Area Code) 电话 \_\_\_\_\_

## Reminder

### 提醒

The doctor completed Student Physical Examination can be completed by your own registered physician in your home or current country or by a local registered physician in a medical clinic in Shanghai.

此表可由您所在地的医生或在上海的医疗机构内完成。