北京顺义国际学校
INTERNATIONAL SCHOOL OF BEIJING
中国北京顺义安华街10号 邮编: 101318
No. 10, An Hua Street, Shunyi District, Beijing 101318, P.R.China
Telephone: 86 10 8149 2345 | Facsimile: 86 10 8046 2003
www.isb.bj.edu.cn

PHYSICAL EXAMINATION AND PROOF OF VACCINATION FORM

Last Name _____ First Name _____ Preferred Name _____ Grade _____

Date of Birth _____ Age _____ Gender ☐ Female ☐ Male
(month/day/year)

PART II - TO BE FILLED OUT BY THE PARENT AND VERIFIED BY THE PHYSICIAN.

IMMUNIZATIONS	RECORD DATES AND ATTACH VACCINE RECORDS NOTE: Copies of Non-English immunization records are acceptable.

Type of Vaccinations		Date received (Month/Day/Year)				
Polio	OPV (Oral)	___/___/___ (2months)	__/__/__ (4months)	__/__/__ (6 Months)	__/__/__ (18months)	_/__/__ (age 4-6 y/o)
	IPV (Inactivated)	_/__/__ (2months)	_/__/__ (4months)		_/__/__ (18months)	_/__/__ (age 4-6 y/o)
DTP or DTap (Diphtheria,Pertussis,Tetanus)		_/__/__ (2months)	_/__/__ (4months)	__/__/__ (6 Months)	_/__/__ (18months)	_/__/__ (age 4-6 y/o)
Tdap or Td (Tetanus Booster)						_/__/__ (booster after age 10)
MMR (Measles/Mumps/Rubella)					_/__/__ (12months)	_/__/__ (age 4-6 y/o)
Hepatitis B (required 3 dose)		_/__/__ (at birth)	_/__/__ (2months)	_/__/__ (6months)		

NOTE TO PHYSICIAN: ISB follows the immunization recommendation from US Center for Disease Control (CDC) guidelines.
(Website: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html)

IMMUNIZATION GIVEN TODAY: _____

- ☐ Up-to- date (see the attached immunization records)
- ☐ Not up-to-date/Specify _____
- ☐ Immunization record attached
- ☐ No Immunization given today

Health Care Provider verifying above immunization history must sign below.		
Signature	**Title**	**Date**

PART III- TO BE FILLED OUT BY PHYSICIAN / HEALTH CARE PROVIDER.

Health Assessment

Date of Assessment: ____/____/____

Height _____ Weight _____
Body Temperature _____
Blood Pressure ___/____ Pulse ____
Build:
- ☐ Slender
- ☐ Medium
- ☐ Heavy
- ☐ Obese

For Female only:
Menses __Yes ___No

Physical Examination

1= Within Normal 2= Abnormal Finding 3= Referred for Evaluation/treatment

HEENT	1 2 3	Neurological	1 2 3	Skin	1 2 3
Lungs	1 2 3	Abdomen	1 2 3	Genital	1 2 3
Heart	1 2 3	Extremities	1 2 3	Urinary	1 2 3
Lymph nodes	1 2 3	Back/Spine	1 2 3		

Hearing Screen

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

	500	1000	2000	4000
Right				
Left				

- ☐ Pass
- ☐ Refer

- ☐ Referred to Audiologist/ENT
- ☐ Permanent Hearing Loss Previously identified
  ____ Right ____Left
- ☐ Hearing aid or other assistive device
- ☐ Unable to test – needs rescreening

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Vision Screening

☐ With Corrective Lenses (check if YES)

Stereopsis __ Pass __ Fail			☐ Not tested	
Distance	Both Eyes	Right Eye	Left Eye	Test used:
	20/	20/	20/	

__ Pass __Referred to eye doctor

__ Unable to test – needs rescreening

TB SCREENING

☐ **No Risk for TB infection identified. TB test is not necessary.**
BCG Received; Yes ☐ No☐

☐ **Risk for TB infection or suspected TB symptoms. This child is recommended to take TB test.**

PPD/ Mantoux Test/ IGRA T-spot

Date ____/____/_____ Result : ☐ Positive ☐ Negative (TST Reading _____ mm)

Or

Chest X-Ray (required if PPD or Interferon positive)

Date: ____/____/_____ ☐ Normal ☐ Abnormal

MEDICAL ASSESSMENT

Attach another page if more space needed if you want to add more information.

Infectious Disease

- ☐ Chicken Pox
- ☐ Infectious Mononucleosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis

Eyes, Ears, Nose, Throat

- ☐ Wear glasses/contact
- ☐ Other Visual Problems
- ☐ Hearing Loss/Deafness
- ☐ Seasonal Allergies
- ☐ Recurrent Sinus Infection
- ☐ Recurrent Ear Infection
- ☐ Recurrent Nose Bleeds

Cardiopulmonary

- ☐ Chest pain with exercise or exertion
- ☐ Syncope or Near Syncope
- ☐ Excessive exertional or unexplained shortness of breath with exercise
- ☐ Excessive exertional or unexplained fatigue with exercise
- ☐ Heart Murmur
- ☐ Elevated Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Heart Disease
- ☐ Heart Palpitations or Irregular beat
- ☐ Marfan Syndrome
- ☐ Congenital Heart Defect
- ☐ Asthma
- ☐ Pneumonia/Bronchitis

G-I

- ☐ Reflux/GERD
- ☐ Ulcer
- ☐ Gall Bladder Disease
- ☐ Hepatitis Type: _____
- ☐ Irritable Bowel
- ☐ Crohn's Diseases
- ☐ Ulcerative Colitis

Genitourinary

- ☐ Cystitis/Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones

Female

- ☐ Severe cramps
- ☐ Irregular periods
- ☐ Heavy flow
- ☐ Ovarian Cyst

Male

- ☐ Testicular Lump
- ☐ Testicular Torsion
- ☐ Undescended /absent testicle

Skin

- ☐ Eczema
- ☐ Acne
- ☐ Hives
- ☐ Chronic rash
- ☐ Tattoos/Piercings
- ☐ Others_____

Musculoskeletal

- ☐ Arthritis
- ☐ Joint Injury
- ☐ Bone fractures
- ☐ Scoliosis
- ☐ Back Pain/Problems
- ☐ Osgood – Schlatter
- ☐ Tendinitis
- ☐ Other Musculoskeletal Disorders

Hematologic /Oncologic

- ☐ Anemia
- ☐ Sickle Cell trait/disease
- ☐ Leukemia/Lymphoma
- ☐ Hemophilia
- ☐ Immune Deficiency

Neurologic

- ☐ ADD /ADHD
- ☐ Seizure Disorder
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Concussion
- ☐ Head Injury with loss of Consciousness
- ☐ Other Neurological Disorders

Mental/ Emotional

- ☐ Anger Management
- ☐ Eating Disorder
- ☐ Trouble Sleeping
- ☐ Mood Disorder
- ☐ Obsessive Compulsive Disorders
- ☐ Depression
- ☐ Other: _____

Metabolic

- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder

Other

- ☐ Anaphylactic Reaction
- ☐ Serious Injury

Medications
(Is this student taking any medication on a regular basis?)

_____

_____

Other Medical Information
(Use this space to provide any additional information.)

_____

_____

_____

*** If more space required Please use other page.**

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***CHRONIC DISEASE ASSESSMENT:**

Asthma	☐ **No** ☐ **Yes** ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced ☐**If YES, please provide a copy of the ASTHMA ACTION PLAN to School.**
Allergies	☐**No** ☐**Yes** ☐Food ☐Insects ☐Medication ☐ Unknown Source History of Anaphylaxis ☐No ☐Yes Epi-Pen required ☐No ☐Yes ☐ **If YES, please provide a copy of the FOOD ALLERGY ACTION PLAN to School.**
Diabetes	☐**No** ☐**Yes** ☐ **If YES, please provide a copy of the DIABETES ACTION PLAN to School.**
Seizures	☐**No** ☐**Yes** ☐ **If YES, please provide a copy of the SEIZURE ACTION PLAN to School.**
Other Chronic Disease:	

CLEARANCE: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

☐ **A. Cleared** for participation of **all** sports without restrictions.
☐ **B. Not cleared** for participation in **any** sport until evaluation/treatment of:
_____
☐ **C. Cleared for limited participation** in the following types of sports only.
_____

Limitation due to: _____

HISTORY REVIEWED AND STUDENT EXAMINED BY:

Physician's/ Provider's Stamp:

Physician's Signature _____

Today's Date _____ Date of Exam: _____