International School Bangkok

Instructions for Completion of New Students Medical Package

All new students must complete the New Students Medical Package. This should be completed no more than 6 months **BEFORE** commencement date at ISB.

Please see the following attached forms which are in the medical package:

1. **Physical Examination Report (New Student)**
   This form must be completed by a licensed Medical Practitioner.
2. **Tuberculosis Screening Form (New Student)**
   This form must be completed by a licensed Medical Practitioner.
3. **Certificate of Immunization**
   This form must be completed by a licensed Medical Practitioner.
4. **Nurse Medication and Emergency Treatment Consent Form**
   This form must be filled out by one or both parents.

Please note:

- These forms must be submitted to the ISB Admissions Office via OpenApply or emailed to <admissions@isb.ac.th>.
- The registered Medical Practitioner does not need to be Thailand based.
- Please ensure all current health issues (physical/social/emotional/behavioral) are discussed with the 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 student's education and care.
- Incomplete medical packages will not be accepted. **ALL** forms must be completed and submitted at the same time.
- If students have anaphylaxis, insulin dependent diabetes or severe/poorly controlled asthma, care plans for these conditions MUST be submitted with the medical package. Additionally, if students have underlying conditions, which is information that requires submission to the family or Health Coordinator, we request that these forms be submitted as well. These forms are available from the ISB Health Center (email: isbnurse@isb.ac.th) or the ISB website under Health Services.
- If a student requires medication to be given on a regular basis a Prescription Medication Consent form must be filled out by the treating medical practitioner and signed by the parents. This form is available from the ISB Health Center (email: isbnurse@isb.ac.th) or the ISB website under Health Services.

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Physical Examination Report (New Student)

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 isbnurse@isb.ac.th or call +66-62-995-9962.

Please complete the information below on behalf of the student:

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

Given name(s) _____ **Gender** _____

Enrolling in grade _____ **Enrolling in academic year** ❑ 24/25 ❑ 25/26

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)		

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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 grades 5-12*

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 - *Students may perform a screening hearing test in lieu of a full audiogram if necessary. Most packages at partner hospitals in Thailand offer a complete audiogram.*

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

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Please list any additional information: _____

_____

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)	

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Tuberculosis Screening Form (New Student)

Please complete the information below on behalf of the student:

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

Given name(s) _____ **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)	

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Certificate of Immunization

Please complete the information below on behalf of the student:

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

Given name(s) _____ **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. Certify the below information on the next page.

REQUIRED Immunizations (please specify date in d/m/y under each required dose):

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTaP					
Tdap - at 10-12 years					
IPV/OPV - Last dose must be given at 4 years or older					
MMR/MMRV					
If MMR/MMRV vaccine was not given, students must have received the following immunizations individually:					
Measles					
Mumps					
Rubella					

OPTIONAL Immunizations (please specify date in d/m/y under each dose received)

Vaccine	Dose 1	Dose 2	Dose 3
Hep A			
Hep B			
Varicella (if MMRV not given)			
Meningococcal			
Japanese Encephalitis			
Rabies			
HPV			
Annual Influenza (most recent dose)			
Covid-19			

Vaccination Certification

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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)	

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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 name(s) _____ **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): _____