International School Bangkok

Instructions for Completion of Returning Student Medical Forms

The following medical package must be completed by a medical practitioner for returning students entering grades 3, 6, and 9, unless a New Student Medical Package has been submitted in the preceding 6 months.

	Physical exam	ECG	TB Screen	Hearing and Vision	Immunization review (please take vaccination record)
Grades	3, 6, 9,	6, 9,	3,6,9	3,6,9	3,6,9

Medication and Emergency Treatment Consent Form

This form must be filled out by one or both parents.

Please note:

- These forms should be submitted to the ISB Health Centre by June 30, 2024.
- **Incomplete medical packages will not be accepted. ALL forms must be filled out and submitted at the same time.**
- Completed forms can be scanned and emailed to nurse@isb.ac.th
- Please ensure all current health issues (physical/social/emotional/behavioral) are discussed with a 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 students education and care.
- If a student has anaphylaxis, Type 1 Diabetes, or moderate to severe asthma, Care Plans for these conditions MUST be submitted with the medical package. These forms are available on the ISB website under Health Services.
- If a student requires medication to be given on a daily basis such as ritalin at lunchtime, a Long Term Prescription Medication Consent form MUST be filled out by the treating medical practitioner and parents. This form is also available on the ISB website under Health Services.
- We encourage all families regardless of grade level to undergo yearly history and physical assessments and consult with your physician with any changes to your child's health.

Please call 02-960-4109 or email isbnurse@isb.ac.th if you have any questions about these forms as we are happy to help.

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Returning Student Physical Examination for students entering Grades 3, 6 and 9.

This form must be completed by a qualified, licensed Medical Practitioner

Student Family Name: _____ Given Names: _____

Date of Birth: _____ (dd/mm/yyyy) Gender ☐ M ☐ F Student entering grade: _____

1. Current Health Issues (include possible triggers, symptoms, and current treatment if any): _____

_____

_____

_____

2. Health Assessment

Weight: _____ Units: lbs. or Kg Height: _____ units: cm or feet/inches BMI_____
Pulse: _____ Blood Pressure_____/_____

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)		

4. Musculoskeletal Evaluation (*Scoliosis Screening*) For students entering Grades 9-12.

Appearance	Normal	Abnormal
Torso Asymmetry		
Truncal Asymmetry		

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5. Cardiac Evaluation *(only for students entering Grades 6 and 9)

ECG result (**please attach a copy of the ECG):** _____

_____

_____

If ECG is Abnormal, please refer the student to a Pediatric Cardiologist for further evaluation and consultation (this may include Echocardiogram or Stress Test, for example). Please indicate any further follow up that is required.

Student Last (Family) Name: _____ Given Names:_____

6. Hearing Screening (for students entering grades 3, 6, 9) Students may opt for a routine hearing screening if unable to perform an audiogram. Please note that most packages from partner hospitals will offer a full audiogram to patients.

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

	1000	2000	4000	6000
Right				
Left				

☐ **Refer to Audiologist** ☐ **Permanent Hearing Loss**

Note: _____

7. Vision Screening (for students entering grades 3, 6, 9)

Corrective lenses or glasses ☐ Yes ☐ No

Distance	Left	Right	Both
	20/	20/	20/

☐ **Pass** ☐ **Refer to an eye doctor**

Note: _____

8. Immunization Review (grades 3, 6, 9)

Please review immunizations and ensure all age appropriate immunizations have been given (unless contraindicated). Please note any immunizations given over the past 12 months and include date/s given: _____

_____

_____

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Please update here if your child has been vaccinated for Covid-19.

Covid-19 Vaccine Name	Date (Shot 1)	Date (Shot 2)	Date (Booster)

9. Summary of Findings (check one)

☐ Well child; no conditions of concern have been identified. The child is cleared to participate in sports, athletics and school activities.

☐ Condition identified and the child is not cleared to participate in school sports, athletics and activities (please explain here including any restrictions and follow up required):

_____

_____

_____

10. Certification

Signature of Medical Provider: _____ Date: _____

Name of Medical Provider: _____ Official stamp:

Qualifications: _____

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Returning student Tuberculosis Screening Form for students entering grades 3, 6, and 9.

Student Family Name: _____ Given Names: _____

Date of Birth (dd/mm/yyyy): _____ Student entering grade: _____

The screening test done should be discussed with your **Medical Practitioner** to determine the most appropriate screening test for the student. ONE of the following tests must be done:

- Mantoux Skin test ☐ Positive ☐ Negative Date (dd/mm/yy): _____
  Induration in mm: _____

OR

- Tuberculosis QuantiFERON test ☐ Positive ☐ Negative Date (dd/mm/yy): _____

OR

- Chest X-ray ☐ Positive ☐ Negative Date (dd/mm/yy): _____

Result: _____

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 evidence of active Tuberculosis (on screening test) and should not be contagious to others.

Signature of Medical Practitioner: _____ Date (dd/mm/yyyy): _____

Name of Medical Practitioner: _____ Official stamp:

Qualifications: _____

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Medication and Emergency Treatment Consent Form

Parents to complete this form

Student Family Name: _____ Given Names: _____

Date of Birth (dd/mm/yyyy): _____ Student entering grade: _____

The School Health Centre provides some over the counter medications that your child may benefit from for certain presentations. We will only administer these medications with parental consent.

Please indicate whether you consent to the nurse administering the following over the counter medication to your child:

Medication:	**Use**	**Yes**	**No**
Acetaminophen/ Paracetamol	Pain, fever		
Ibuprofen/advil	Pain, fever		
Decongestant (e.g. norfed)	Nasal and sinus congestion		
Antacid (e.g. antacil or gaviscon)	Indigestion		
Antihistamine (e.g. zyrtec)	Allergy		

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 during 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 is required to sign; both may sign if you prefer.)

Signed (Parent): _____ Signed (Parent): _____

Name: _____ Name: _____

Telephone Number: _____ Telephone Number: _____

Date (dd/mm/yyyy): _____ Date (dd/mm/yyyy): _____