



DAEGU INTERNATIONAL SCHOOL

Medical Form Guideline

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Medical Form Guideline

(ENGLISH INSTRUCTION)

- 1) Pages 1 and 2 should be completed by the parent(s).
- 2) Page 3 is for the general medical checkup required before admission. (All relevant lab tests must be completed.) Page 3 must be completed by a licensed physician.
- 3) Additional document to be submitted
 - A photocopy of the immunization record
(If all items are completed and confirmed by the physician, separate submission is not required.)
 - Either a TB skin test or a chest X-ray is required.
(Only one is needed; however, if the skin test result is positive, a chest X-ray must also be submitted.)
- 4) Student photo must be attached to Page 1. (Any size is acceptable.)

메디컬폼 가이드라인

(한국어 안내)

- 1) 1~2페이지는 보호자께서 작성해 주시기 바랍니다.
- 2) 3페이지는 종합 건강검진(랩 테스트 포함)을 위한 항목입니다. 3페이지는 반드시 의사가 직접 작성해야 합니다.
- 3) 메디컬 폼(총 3장) 외 추가 제출 서류:
 - 예방접종기록표 사본
(모든 항목이 기입되어 있고 의사의 확인을 받은 경우 별도 제출 불필요)
 - 결핵 검사(TB Skin Test 또는 흉부 X-ray 중 택 1)
(Skin Test 결과가 양성일 경우 X-ray 추가 촬영 필수)
- 4) 1페이지 상단에 학생 사진 부착 (사진 크기 제한 없음)



DAEGU INTERNATIONAL SCHOOL MEDICAL HISTORY FORM

**To be completed by PARENTS and returned to the ADMISSIONS OFFICE*

Student's name: _____ Nick name: _____ Current Grade: _____
Last/Family Middle First

Date of Birth: _____ Gender: ☐ / ☐ Blood Type: _____
MM/DD/YYYY Female Male

Nationality: _____ **Please list all your nationalities*

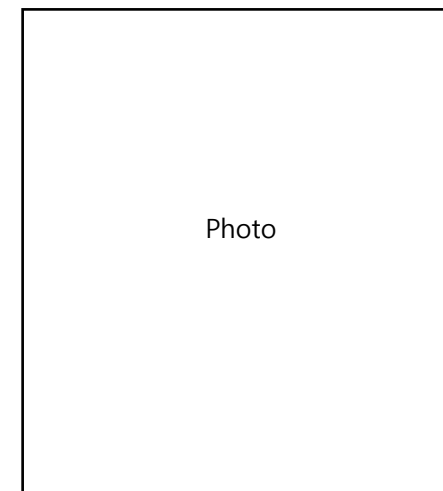
Home Address: _____

Phone(Home): _____

Father's Name: _____

Mother's Name: _____

Emergency Contact Information
Name: _____
Relation to child: _____
Phone: _____



Phone (mobile): Father's: _____ Mother's: _____

PERMISSION FOR GIVING MEDICATION FOR MINOR COMPLAINTS **Please check Yes or No*

The following list of common procedure/medication for which you would like to grant the permission of the nurse to administer to your child if necessary.		YES	NO		YES	NO
	Acetaminophen(Tylenol)			Robitussin(Cough Syr)		
	Pepto-Bismol(Festal)			Advil(Ibuprofen)		
	Benadryl(zyrtec)			Sudafed(Kossak)		

PERMISSION FOR EMERGENCY TREATMENT

In the event that I cannot be reached in an emergency, I give permission for my child to receive medical treatment including transport to the most accessible hospital, as deemed necessary by school authorities.

Parent Name: _____ Parent's Signature: _____ Date: _____

MM/DD/YYYY

*To be completed by **PARENTS**

Student's name:_____ Current Grade:_____ Date of Birth(MM/DD/YYYY):_____

IMMUNIZATION *Please PRINT the dates (MM/DD/YYYY) of each immunization received. Attach additional documents as necessary.

	DTaP(Diphtheria, tetanus and pertussis)		POLIO (OPV/IPV)		MMR(Measles, mumps, and rubella)		HEPATITIS B		Tdap		TB Skin Test / Chest X-ray
Recommended Childhood Immunization Schedule		MM/DD/YYYY		MM/DD/YYYY		MM/DD/YYYY		MM/DD/YYYY		MM/DD/YYYY	Date:
	2mos		2mos		12-15 mos		#1		11-16yrs		
	4mos		4mos		4-6yrs		#2				
	6mos		6-18 mos				#3		Chicken Pox		Result:
	15-18mos		4-6yrs						12-15mos	MM/DD/YYYY	
	4-6yrs										

PAST MEDICAL HISTORY *Please check Yes or No

	YES	NO		YES	NO	Fractures	Date (MM/DD/YYYY)
Chicken pox			Convulsions				
Measles			Meningitis				
Rubella			Hepatitis			Operations	Date (MM/DD/YYYY)
Mumps			Rheumatic Fever				
Whooping cough			Pneumonia				
Poliomyelitis			Tuberculosis			Others	Date (MM/DD/YYYY)
Substance Abuse			Heart Disease				
Others:							

PRESENT MEDICAL HISTORY *Please check Yes or No

	YES	NO	IF YES, please describe in detail
● Current Medical Concern?			
● Current Medication?			
● Allergies?			
● Eye/ Vision problems?			
● Ear/ Hearing problems?			
● Bone/ Joint problem?			

Parent Name:_____ Parent's Signature:_____ Date:_____

MM/DD/YYYY



DAEGU INTERNATIONAL SCHOOL

REPORT OF MEDICAL EXAM

**To be completed by a Physician and returned to the ADMISSIONS OFFICE*

____ (M / F)
 Name (Last, First, Middle) Grade Date of Birth(MM/DD/YYYY)

(Medical Exam must be current- within 6 months of entry)

Key: (N) Normal (SR) See Report

Age _____ BP _____ / _____ Hgt. _____ Wgt. _____

Nutritional Status: _____ Skin: _____

Eyes: _____ sclera _____ pupils _____ vision: R _____ L _____ Glasses _____

Ears: _____ canals: R _____ L _____ drums: R _____ L _____

Hearing: R _____ L _____

Nose: _____ septum _____ turbinates _____

Mouth: _____ lips _____ tongue _____ pharynx _____

Teeth: _____ gingiva _____

Neck: _____ mobility _____ lymph nodes _____ thyroid _____

Throat: _____ shape _____ symmetry _____

Lungs: _____

Heart: _____ rate _____ rhythm _____ murmur _____

Abdomen: _____ liver _____ spleen _____ hernias _____

Spine: _____

Lower Extremities: _____ ROM _____ development _____ strength _____

Upper Extremities: _____ ROM _____ development _____ strength _____

Neurological exam: _____ Attention Deficit Disorder: _____

***Please administer the following tests as well as any others needed.**

● TUBERCULIN SKIN TEST

Date(MM/DD/YYYY) _____ Result _____

● CHEST X-RAY

Date(MM/DD/YYYY) _____ Result _____

● LAB TEST

URINALYSIS: Date(MM/DD/YYYY) _____ Result _____

HEMOGLOBIN: Date(MM/DD/YYYY) _____ Result _____

OTHERS: Date(MM/DD/YYYY) _____ Result _____

***Please check the evidence of the following required immunization:**

DTaP #1 _____	IPV(Polio) #1 _____	MMR #1 _____	Tdap _____	Hepatitis B #1 _____
#2 _____	#2 _____	#2 _____		#2 _____
#3 _____	#3 _____			#3 _____
#4 _____	#4 _____			
#5 _____				

I have seen the evidence that these have been administered.

YES _____ NO _____

****Please be strict on immunization.*** Students who have lost records must have one IPV, DT, MMR booster along with Tuberculin skin test.

Please administer appropriate immunization to complete records.

**Please explain if there is anything else the school should know about this student.*

● Comments _____

● On the basis of the examination on this day, I approve this child's participation in **physical education** activities, including **inter-scholastic sports**, unless otherwise specified above.

Yes _____ No _____

***I certify that this student has been examined by me.**

Physician's Name: _____ Name of Clinic/Hospital: _____

Phone # of Clinic/Hospital: _____

Signature of Physician: _____ Date(MM/DD/YYYY) _____