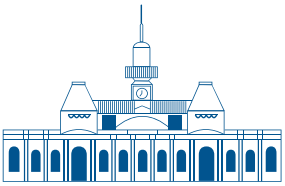

International School
HO CHI MINH CITY

Energized · Engaged · Empowered

PASSPORT PHOTO

Address: 28 Vo Truong Toan St., An Phu, Dist. 2, HCMC • Phone: (84-8) 3898 9100• Fax: (84-8) 3898 9382 • Email: admissions@ishcmc.edu.vn • Website: www.ishcmc.com

MEDICAL EXAMINATION FORM

• This form is required for all applications to International School Ho Chi Minh City (ISHCMC) and must be signed by a parent before a student attends classes or participates in any activities.

• This form must be completed no earlier than six months prior to the start of school. Please see the accompanying information sheet for a list of recommended clinics in Ho Chi Minh City.

• ISHCMC reserves the right to withhold a student from classes until this form is completed in full and returned to the admissions office.

Student's name: . . . . . .

(Family) *(First)* *(Middle)*

Date of birth: . . . . . (day/month/year) Sex: ☐ Male ☐ Female

PART 1: TO BE FILLED OUT AND SIGNED BY PARENTS

PARENT/GUARDIAN CONTACT Name: . . . . . Phone: . . . . .

Relationship: . . . . . Email: . . . . .

Name: . . . . . Phone: . . . . .

Relationship: . . . . . Email: . . . . .

Local doctor or health care provider in HCMC: . . . . . Phone: . . . . .

EMERGENCY CONTACT Name (not parent): . . . . .

Relationship: . . . . . Phone: . . . . .

Medical Insurance: ☐ Yes ☐ No Name: . . . . .

Phone: . . . . . Insurance number: . . . . .

If the student requires medication to be given during school hours please complete a *Request to Administer Medication Form*. All medications along with the form must be submitted to the school clinic. Medications need to be in the original pharmacy/doctor's containers and marked with the student's name, name of drug, dosage, schedule and instructions. All information must be in English. Students are not permitted to carry any medication in their personal belongings while at school.

If the student has significant allergies requiring emergency medications or if the student has a medical diagnosis requiring the nurse's attention, please contact the school to set up an appointment to meet with the School Health Center prior to the student's commencement at ISHCMC.

Have you handed in the photocopy of your child's immunisation records? ☐ Yes ☐ No
If no immunisation records are available, please provide results of essential blood tests: Hep A, Hep B, MMR

Permission to administer Paracetamol: ☐ Yes ☐ No

Emergency Treatment Authorization: In the event of an emergency, when immediate observation or treatment is deemed necessary in the judgment of the school Health Center staff, I authorize and direct the school authorities to send my child to the medical facility most readily available. If an ambulance is required this will be at the parent's expense.

Parent / Guardian Signature. . . . . Date. . . . . .

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL IN WRITING OF ANY CHANGES TO THE INFORMATION GIVEN IN THIS FORM e.g. changes of address, telephone number, physical condition or medications.

School Clinic *Email: nurse@ishcmc.edu.vn. Phone: 08 3898-9100 Ext:105*

PART 2: TO BE FILLED OUT BY A DOCTOR

Student's name: . . . . . .

(Family) *(First)* *(Middle)*

HEALTH HISTORY

Has the student exerienced any of the following in the past? Please mark "X" to indicate Yes or No

	Yes	No
Asthma		
Chronic/recurrent illness		
Hospitalizations/surgery		
Other (ADHD, Autism, etc.)		
Injury treated by physician		
Congenital abnormality		
Heat exhaustion/stroke		
Dizziness/fainting/headaches		
Concussion		
Eyes:related conditions/wears glasses/contacts		
Dental caps/bridges/braces/plates/decay		
Cardiac abnormalities/ heart/murmurs		
Problems with bladder/kidneys		
Skin conditions/ Eczema		
Skeletal (fractures, dislocations/sprains/scoliosis)		

ALLERGIES: . . . .

. . . . . .

Height: . . . . . Weight: . . . . . .

B/P: . . . . . Heart Rate: . . . . . .

Current Medications	Dosage	Purpose

	Normal	Abnormal
Head		
ENT		
Chest		
Abdomen		

Summary: If you answered Yes to any of the above, please provide details:

.....

.....

PE Participation Approved? ☐ Yes ☐ No Competitive Sports Participation Approved? ☐ Yes ☐ No

IMMUNISATION HISTORY

Photocopies of records must be submitted or parents/doctor to transcribe each vaccine below

School required:	Date	Date	Date	Date	Date	Remarks
DPT (Diphtheria, Pertussis, Tetanus)						
Polio						
Measles						
Mumps						
Rubella						
Hepatitis A						
Hepatitis B						
Haemophylus Influenza (Hib)						
Chicken Pox (Varicella)						
Recommended for Vietnam:	**Date**	**Date**	**Date**	**Date**	**Date**	**Remarks**
Rabies						
BCG (TB)						
Typhoid						
HPV						
Japanese Encephalitis						
Meningococcal						
Pneumococcal						

Doctor Signature/Stamp:. . . . . **Date** . . . . . .

☐ **Immunisation current for age, as certified by a doctor.**