CHADWICK INTERNATIONAL

PHYSICIAN'S EXAMINATION (NEW STUDENT)

All fields must be completed.
Please have this form filled out by a physician and upload on the Online Health Forms.

NAME	Last	First	Middle	Date of Birth(mm/dd/yy)	/ /	GRADE		SEX	

PART 1. PHYSICAL EXAMINATION

HEIGHT	cm	WEIGHT	Kg	PULSE	BPM	BLOOD PRESSURE	mmHg	VISION(with correction)	R	L

	Within Normal	Describe Abnormal Finding		Within Normal	Describe Abnormal Finding
HEENT			Genitalia/hernia		
Dental/Mouth			Skin		
Heart			Neurologic		
Lungs			Orthopedic		
Abdomen			Scoliosis		

PART 2. SCREENINGS

TB screening must be done within 2 years prior to first school day / Other tests within 6 months.

1. TUBERCULOSIS Screening (check one) History of BCG vaccination should NOT be exempted from TST unless positive result history from a prior test	2. URINALYSIS (results)	3. HEMOGLOBIN (results)
☐ Tuberculin Skin Test / ☐ IGRA Date read: ____/____/____ TST Reading: _____mm Result: pos. / neg. ☐ Chest X-ray (required if TST or IGRA is positive): Date : ____/____/____ Result: _____		

PART 3. IMMUNIZATION RECORD (mm/dd/yy)

NOTE : If evidence of immunization cannot be provided to physician, either appropriate immunization or a positive serological test for immunity to the disease is required.

VACCINE	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose	VACCINE	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
DPT/DTaP	2mos / /	4mos / /	6mos / /	15-18mos / /	4-6yrs / /	Hepatitis B	Birth / /	1-2mos / /	6mos / /		
Td/TdaP	11-12yrs / /					Varicella (Chickenpox)	12-15mos / /	4-6yrs / /	Disease history mm/dd/yy	/ /	
POLIO (OPV or IPV)	2mos / /	4mos / /	6-18mos / /	4-6yrs / /		*Japanese Encephalitis (☐IJEV ☐LJEV)	/ /	/ /	/ /	/ /	/ /
MMR	12-15mos / /	4-6yrs / /				Other( )	/ /	/ /	/ /	/ /	/ /

PART 4. SUMMARY OF FINDINGS

This student may (check one) :

☐ Participate fully in the school program and athletic activities/competitive sports
☐ Participate in the school program and athletic activities/competitive sports with the following restriction/adaptation
: _____

Allergy : ☐NO ☐YES (Explain : _____)

History of Anaphylaxis ☐No ☐Yes (If yes, please provide a copy of *Medication Request Form* and *Epi-Pen* to School health office)

Response required : ☐None ☐Epi-Pen ☐Other :_____

Asthma : ☐NO ☐YES ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent ☐Exercise induced

Inhaler required ☐NO ☐YES (If yes, please provide a copy of *the Asthma Action Card* and *Inhaler* to School health office.)

Individualized Health Care Plan needed : ☐NO ☐YES (e.g., Diabetes, Seizure disorder, ADD/ADHD, Anxiety disorder, etc.)
(Explain: _____)

Medication: ☐NO ☐YES (Explain: _____)

Comments: :

Physician's Name & Signature : _____

Name of Hospital(Clinic) : _____

Date(mm/dd/yy) : ____/____/____ **Official Stamp :**

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