Medical History Form

Student's Name						Date of Birth			Male () Home Room		
(Last, First, Mid	dle Init	tial)							Female ()		
Father's Name				Organization		Phone (office)			Emergency Name & Phone		
(Last, First, Mid	dle, Ini	itial)									
Home Address						Phone (home)					
Blood Type Current Medica				Problems							
Past Medical History											
Fractures		Convulsions		Allergies	Fractures	ractures Date		Operations		Date	Other
Measles		Meningitis									
Rubella		Hepatitis									
Mumps		Rheuma	itic Fever								
Whooping cough		Pneumo	nia								
Poliomyelitis		Tubero	culosis								
Substance Abuse											
IMMUNIZATION RECORD											
			DPT	Pol	io	MMR	TB S	Skin Te	est		D.T. Booster
Recommended	2 n	nos		2 mos	12-15 n	108	every 2 yrs			11-16 yrs	1
Childhood	4 n	nos		4 mos	4-6 yts	3					
Immunization	6 r	nos		6 mos							
Schedule	12-	-18 mos		4-6 yts							
	4-6	3 yts									
Vision Problems				Permission is g							
			a) Tylenol		Peptobismol	\ /		Parent Signature		Date	
Hearing			b) Aspirin		Treatment of illness						
			c) Throat Lozen d) Cough syrup	ges () g)	Emergency care ()						
				u oougii syrup	SCHOOL SCREENIN	NG RECORD					
Date	Grade	Hei	ght (Inches)	Weight (lbs.)	R Visio		R	Hearin	g L		
			9 (,								
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Kwangju Foreign School 106 Samso-ro, Buk-gu Gwangju Korea 500-480 Tel/Fax (062) 575-0900/ 575-0902

REPORT OF MEDICAL EXAM	Hemoglobin (Results): TB Skin Test(Results):					
Name (Last, First, Middle) Grade Date of Birth						
	KFS requires evidence of immunization for the following:					
(Medical Exam must be current - within12 months of entry date	DPaT #1 #2 #3 #4 #5 Polio(IPV/OPV) #1 #2 #3 #4					
	MMR #1 #2 #3 #4 Hepatitis B #1 #2					
(N) Normal (SR) See Report(Attached)	I have seen evidence that these have been administered					
Age BP Hgt Wgt	I have seen evidence that these have been administered. YES NO					
Nutritional Status :						
Skin :	Please be strict on immunization. Student who has lost record must have on IPV,					
Eyes Sclera Vision R L Glasses	DT, MMR booster along with Tuberculin skin test.					
Ears Canals R L Drums R L						
Hearing R L						
Nose Septum Turbinates	Comments:					
Mouth Lips Tongue Pharynx						
Teeth Gingiva						
Neck Mobility Lymph Nodes Thyroid						
Throat Shape Symmetry						
Lungs						
Heart Rate Rhythm Murmur						
Abdomen Liver Spleen Hernias	I Certify that this student has been examined by me. This examination shows that					
Spine	this student is physically able to participate in physical education activities,					
Lower Extremities Range of Motion Development Stren	gth Including inter-scholastic sports, unless ohterwise specified above.					
Upper Extremities Range of Motion Development Streng	gth					
Neurological Exam	Physician's Signature :					
Attention Deficit Disorder	Clinic / Hospital :					

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

Urinalysis (Results):

Date : _____