



# International School Bangkok

## Comprehensive Physical Examination Report

Please call +662-960-4109 or write to [nurse@isb.ac.th](mailto:nurse@isb.ac.th) if you have any questions about this form.

A qualified, licensed medical doctor must complete this form. The examination should be completed no more than 6 months prior to the first day of attendance at ISB and **must be on file in the ISB Admissions Office before the student can be authorized to start school. Sections 1, 2, 3, 4, and 6 are required of ALL applicants. Section 5 is for students entering grades 5 -12 only.**

Student Last (Family) Name \_\_\_\_\_ Given Names \_\_\_\_\_

Date of Birth \_\_\_\_\_ (Day/Month/Year) Gender: Male / Female Grade Level at ISB \_\_\_\_\_

### 1. Health Assessment:

Weight: \_\_\_\_\_ Units: lbs or KGs Height: \_\_\_\_\_ units: cm or feet/inches

Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

### 2. Physical Examination:

Medical Appearance	Normal	Abnormal (referred for evaluation or treatment)
Eyes, ears, nose, throat		
Lymph Nodes		
Lungs		
Heart		
Abdomen		
Skin		
Musculoskeletal: Head & Neck		
Musculoskeletal: Back – include scoliosis screening		
Extremities (to include arms, legs, elbows, knees, hips and ankles)		

### 3. Hearing Screening:

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

	1000	2000	4000	6000
Right				
Left				

Refer to Audiologist  Permanent Hearing Loss  Left ear  Right ear

### 4. Vision Screening:

Distance	Left	Right	Both
	20/	20/	20/

Pass  Refer to an eye doctor

With corrective lenses or glasses (check if yes) Color Deficiency Test:  Pass  Fail

Student Last (Family) Name \_\_\_\_\_ Given Names \_\_\_\_\_

**5. Cardiac Evaluation** (Required of **all students entering grades 5-12**; Optional for students in Pkg – g 4)

	Normal	Cardiac Evaluation
Brachial Artery Pulse		
Femoral Artery Pulse		
Heart Murmur		
ECG Electrocardiogram		

***\*If ECG is Abnormal, please refer to Pediatric Cardiologist for further evaluation and consultation (this can include echocardiogram; ultrasound of the heart or Stress Test, for example). Please indicate any further follow up that is required.***

**6. Summary of Findings (check one):**

Well child; no conditions of concern have been found or 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):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. Certification**

Signature of Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Position or Title \_\_\_\_\_

Printed name of Medical Provider \_\_\_\_\_

Official Stamp or Seal
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Please provide the official stamp or seal of the doctor, clinic or medical facility in the area provided to the right.