KOREA INTERNATIONAL SCHOOL

27, Daewangpangyo-ro 385beon-gil, Bundang-gu, Seongnam-si , Gyeonggi-do, 13543

Tel:+82-31-789-0549, 0556 / Fax:+82-31-748-0509 www.kis.or.kr

<PART A-2> PHYSICAL EXAMINATION CERTIFICATE

(TO BE COMPLETED BY MEDICAL DOCTOR)

(Date of Exam - within 6 months before entry to school)

Student's Name(Last, First, Middle)	Date of Birth (mm/dd/yyyy)	Gender	Grade

*Color-blindness test≥for ***4th*** grade.

Height_____	Weight_____	BMI_____ BP_____
Vision Screening	Rt_____	Lt_____
*Color-blindness test**	☐Within normal	☐Concern identified_____
Hearing Screening	☐Pass	☐Fail
Dental Assessment	☐Within normal	☐Problem identified: Referred for treatment
Developmental Evaluation	☐Within normal	☐Concern identified_____

Physical Exam	Normal	Describe Abnormal
Skin		
Nose and Throat		
Heart		
Lungs		
Gastrointestinal		
Genitourinary		
Neurological		
Musculoskeletal		

Please administer the following tests:

Tuberculosis	*All grades*	☐Skin test ☐Chest X-ray ☐IGRA test Date MM/DD/YYYY Result _____ (Chest X-ray is required if the TB skin test result is positive.)	
Blood test	*All grades*	**Blood type**	A / B / O / AB Rh + / –
	≥7*th grade*	**HBsAg**	☐negative ☐positive
	≥10*th grade*	**Hemoglobin**	_____g/dl
Urine test	*All grades*	☐Normal ☐Abnormal finding _____	

Please check for evidence of the following required immunizations.

DTaP	#1__ #2__ #3__ #4__ #5__	**Td**	#1__
IPV	#1__ #2__ #3__ #4__	**Hib**	#1__ #2__ #3__ #4__
MMR	#1__ #2__	**PCV**	#1__ #2__ #3__ #4__
HepB	#1__ #2__ #3__	**HepA**	#1__ #2__
Varicella	#1__ #2__		
***HPV**	#1__ #2__ #3__	***JE**	#1__ #2__ #3__ #4__ #5__

* Additionally recommended immunizations in Korea.(not required for admission)

I have verified that these immunizations have been administered.

Yes_____ No_____

Please be strict on immunizations. Administer appropriate immunization to complete.

Summary of findings (check one):

☐ Well child: no conditions identified of concern to school program/activities.

☐ Conditions identified that are important to schooling or physical activity.

(please explain): _____

_____

Print name of physician _____

Signature of physician _____

Name of Clinic/Hospital _____ **Date** (mm/dd/yy) _____

KOREA INTERNATIONAL SCHOOL (A)

<PART A-1> HEALTH INFORMATION FORM

(TO BE COMPLETED BY PARENT)

***Please return completed form to the Nurse's Office**

Student's Name	Last	First	Middle	Date of Birth (mm/dd/yyyy)	Male ( ) Female ( )	Grade:
Mother's Name (Last, First)		Father's Name (Last, First)		Cell Phone Father: Mother:	Emergency Contact Information Name: Relationship: Phone:	
Home Address						

HEALTH HISTORY

ALLERGIES ☐ No ☐ Yes (If yes, list specific allergy, reactions, and treatment)

☐ Food: ☐ Medicine:

☐ Seasonal ☐ Other:

MEDICATION

Does your child take any medication on a regular basis? ☐ No ☐ Yes

☐ Medication taken at school – Name of medication:

☐ Medication taken at home – Name of medication:

HEALTH CONCERNS ☐ No ☐ Yes **(If yes, please explain):**

☐ ADHD (Attention Deficit Hyperactivity Disorder) ☐ Asthma ☐ Autism ☐ Mental / Physical ☐ Diabetes

☐ Heart ☐ Hearing ☐ Vision ☐ Surgery ☐ Other

Had Chickenpox disease? ☐ No ☐ Yes

REQUIRED IMMUNIZATIONS Please fill out the date or attach a copy of official immunizations report in English/Korean.

*JE, BCG and HPV are additionally recommended in Korea, not required for admission.

HepB (Hepatitis B)	**DTaP** (Diphtheria, Tetanus, Pertussis)	**Hib** (Haemophilus influenza type b)	**PCV** (Pneumococcus)	**IPV / OPV** (POLIO)	**MMR** (Measles, Mumps, Rubella)	***HPV** (Human Papilloma Virus)	***JE** (Japanese Encephalitis)
① MM/DD/YYYY	① MM/DD/YYYY	① MM/DD/YYYY	① MM/DD/YYYY	① MM/DD/YYYY	① MM/DD/YYYY	① MM/DD/YYYY	① MM/DD/YYYY
② MM/DD/YYYY	② MM/DD/YYYY	② MM/DD/YYYY	② MM/DD/YYYY	② MM/DD/YYYY	② MM/DD/YYYY	② MM/DD/YYYY	② MM/DD/YYYY
③ MM/DD/YYYY	③ MM/DD/YYYY	③ MM/DD/YYYY	③ MM/DD/YYYY	③ MM/DD/YYYY	**HepA** (Hepatitis A)	③ MM/DD/YYYY	③ MM/DD/YYYY
Var (Varicella)	④ MM/DD/YYYY	④ MM/DD/YYYY	④ MM/DD/YYYY	④ MM/DD/YYYY	① MM/DD/YYYY	***BCG** (Tuberculosis)	④ MM/DD/YYYY
① MM/DD/YYYY	⑤ MM/DD/YYYY	**Td/Tdap(11~12yrs)**	① MM/DD/YYYY		② MM/DD/YYYY	① MM/DD/YYYY	⑤ MM/DD/YYYY

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATION AT SCHOOL

Over-the-counter medication may be administered in the Nurse's Office as needed with permission of the student's parent. ***Please check each medication for which you are giving permission.***

Antipyretic medicine	☐ Tylenol	☐ Advil (Ibuprofen)	☐ Tylenol cold	
Digestant medicine	☐ Festal (Pepto-Bismol)	☐ Baekcho syrup (Herbal syrup)	☐ Buscopan (Antispasmodics)	☐ Smecta (Antidiarrheal)
Allergy medicine	☐ Zyrtec	☐ Clarityne	☐ Cospen (Actifed)	

Form last updated: May 2017

Print name of parent _____

Signature of parent _____

Date (mm/dd/yy) _____