THE INTERNATIONAL SCHOOL OF KUALA LUMPUR
2, Lorong Kelab Polo Di Raja, 55000 Kuala Lumpur, Malaysia
Phone: (603) 4813 5004 | Fax: (603) 4813 5104 | Email: admissions@iskl.edu.my

# STUDENT HEALTH FORM AND PHYSICAL EXAMINATION RECORD

*This Health Form and the Physical Examination Record will be kept in the ISKL Health Services Office.*

***PHOTO***

**FOR OFFICE USE ONLY:**

SCHOOL YEAR _____ GRADE _____ AGE _____

STUDENT ID# _____

***The information on this form will be confidential and will only be shared with school personnel on a need-to-know basis.***

## STUDENT AND FAMILY INFORMATION

Student's Name: _____ Preferred Name: _____
*Family Name First Name Middle Name*

Sex: M / F Date of Birth: _____ / _____ / _____ Nationality: _____
*DD MM Y Y*

Student resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian

Mother/Guardian Name: _____ Contact No: _____

Father/Guardian Name: _____ Contact No: _____

If student will be staying with a guardian please provide contact information for the parents:

Parent Phone Number: _____ Parent Email: _____

## FOR EMERGENCY USE (If Parents Cannot Be Reached)

Primary Contact: _____ Phone #: _____ Hand Phone #: _____

Secondary Contact: _____ Phone #: _____ Hand Phone #: _____

Local Doctor or Health Care Provider: _____ Phone #: _____

**Permission for Emergency Care**

Permission is hereby given for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible. I certify that all information provided on this document is complete and correct.

Name: _____ Signature: _____ Date: _____
*Parent / Guardian*

STUDENT NAME: _____

**NOTE: Please notify the appropriate divisional office of any changes in contact information**

## STUDENT HEALTH HISTORY (To be completed by Parents)

***Does your child have a history of any health concerns or medical conditions?***

***Please complete this section prior to your physical examination and bring it with you to have the doctor review.***

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Neurological<br>(e.g., Seizures, Headaches, Syncope) | | | Endocrinology/Hormonal<br>(e.g., Diabetes, Thyroid) | | |
| Heart Problems<br>(e.g., Rhythm & Sounds) | | | Mouth<br>(e.g., Teeth, Gums, Braces) | | |
| Breathing or Lungs<br>(e.g., Asthma, Tb, Cystic Fibrosis) | | | Nose<br>(e.g., Congestion, Nose bleeds) | | |
| Muscles, Joints, Bones | | | Ears<br>(e.g., Infections, Grommets, Hearing) | | |
| Stomach, Digestion | | | Blood Disorders<br>(e.g., Anemia, G6PD, Hemophilia) | | |
| Skin Problems<br>(e.g., Eczema, Rashes, Scars, Psoriasis) | | | Gynecological | | |
| Kidney, Bladder | | | Psychological/Developmental<br>(e.g., Depression, Bipolar, Anxiety) | | |
| Attention Deficit Disorder | | | Nutritional Status<br>(e.g., Over/Under weight, Eating disorder) | | |
| Vision, Eyes | | | Hospitalizations/Surgeries | | |
| Allergies<br>(e.g., Food, Medicine, Environmental) | | | Regularly Prescribed Medication | | |

Describe, in detail, any conditions marked YES above and the dates involved:

1. _____

2. _____

3. _____

4. _____

5. _____

## PERMISSION TO GIVE MEDICATIONS

While at school, all medications, whether prescription or over-the-counter, must be dispensed from the Health Services Office. With the exception of asthma inhalers and Epi-pens, students are not allowed to carry any medicines with them at school.

Please check Yes or No for each medication & sign/date. (Note: Parents of Elementary School students will be called prior to giving any medication.) For a description of medications, please contact either ampangnurse@iskl.edu.my (Middle & High School) or melawatinurse@iskl.edu.my (Elementary School).

| | | | | | |
|---|---|---|---|---|---|
| Panadol | ☐ Yes | ☐ No | Throat Lozenges | ☐ Yes | ☐ No |
| Maalox | ☐ Yes | ☐ No | Ibuprofen | ☐ Yes | ☐ No |
| Panadol Menstrual | ☐ Yes | ☐ No | Panadol Cold | ☐ Yes | ☐ No |
| Antihistamine | ☐ Yes | ☐ No | Cough Suppressant | ☐ Yes | ☐ No |

Name: _____ Signature: _____ Date: _____

*Parent / Guardian*

STUDENT NAME: _____

## PHYSICAL EXAMINATION RECORD (Page 1 of 2)

**(To be completed by the family's Medical Doctor, Physician Assistant or Nurse Practitioner)**

***Please review Page 2 of 4 – Student Health History, prior to physical exam***

Height: _____ Weight: _____ BMI: _____ Blood Group (if known): _____ Blood Pressure: _____

***Vision:*** Distance: R _____ L _____ Reading: R _____ L _____ Corrective Lens: ☐ Yes ☐ No

If wears corrective lens: ☐ Contacts ☐ Glasses ☐ Should wear at all times ☐ Can wear during class only

***Hearing:*** Audiometry: R _____ L _____

Recommendations: _____

## Immunization History (To be completed by the family's Medical Doctor, Physician Assistant or Nurse Practitioner)

***Please review and transcribe dates of immunizations from original immunization records.***

### Required Immunizations

**Diptheria, Tetanus, Pertussis** _____ _____ _____ _____ _____ _____
*4 doses by age 2 (DTaP)* *1 dose at age 4-6 (DTaP)* *Booster at age 11-12 (TdaP)*

**Polio** _____ _____ _____ _____
*3 doses by age 2* *Booster at age 4-6*

**Hib**
(for students 5 and under) _____ _____ _____ _____
*3 doses by age 2* *Booster at age 4-6*

**MMR**
(Measles, Mumps, Rubella) _____ _____
*1 dose after age 12 months* *1 Booster at age 4-6*

**Varicella**
(Chicken pox) _____ _____ or _____
*1st dose* *2nd dose* *Age child had Chicken pox illness*

**Hepatitis B** _____ _____ _____ **Hepatitis A** _____ _____
*3 doses* *2 doses*

**Meningococcal (ACWY)**
(Meningitis) _____ _____
*1 dose at age 11-12* *Booster at age 16 (or 5 years after first vaccine)*

### Recommended Immunizations

Annual Influenza _____ _____ _____

Human Papilloma Virus (HPV) _____ _____ _____

Typhoid _____ _____ _____

### Other Immunizations

Rabies _____ _____ _____

Yellow Fever _____ _____ _____

Japanese Encephalitis _____ _____ _____

### Tuberculosis Requirements

***Because Malaysia has a high rate of Tuberculosis, ISKL requires proof of no active Tb every two years.***
Please provide documentation of **ONE** of the following:

Mantoux or PPD skin test Date: _____ Result: _____ mm

Chest X-ray Date: _____ ☐ Positive ☐ Negative

Blood Test Date: _____ ☐ Positive ☐ Negative

If the child is 5 years or younger and received the BCG vaccine as an infant, indicate date: _____

***I certify that I have reviewed a record of this child's immunizations and transcribed it accurately. The student has met all of the school-required immunizations.***

Name of Physician: _____ Signature & Title: _____ Date: _____
*Physician Signature & Physician Stamp*

STUDENT NAME: _____

## PHYSICAL EXAMINATION RECORD (Page 2 of 2)

**(To be completed by the family's Medical Doctor, Physician Assistant or Nurse Practitioner)**

| | ABNORMAL | NORMAL | | ABNORMAL | NORMAL |
|---|---|---|---|---|---|
| Neurological (e.g., Seizures, Headaches, Syncope) | | | Endocrinology/Hormonal (e.g., Diabetes, Thyroid) | | |
| Cardiac (e.g., Rhythm & Sounds) | | | Mouth (e.g., Teeth, Gums, Braces) | | |
| Respiratory/Pulmonary (e.g., Asthma, Tb, Cystic Fibrosis) | | | Nose (e.g., Congestion, Nose bleeds) | | |
| Musculo Skeletal (e.g., Postural, Joint Problems, Motor Development) | | | Nutritional Status (e.g., Over/Under weight, Eating Disorder) | | |
| Gastrointestinal (e.g., Upper & Lower GI) | | | Blood Disorders (e.g., Anemia, G6PD, Hemophilia) | | |
| Integumentary (e.g., Eczema, Rashes, Scars, Psoriasis) | | | Psychological/Developmental (e.g., Depression, Bipolar, Anxiety) | | |
| Urological | | | Ears (e.g., Infections, Grommets, Hearing) | | |
| Attention Deficit Disorder | | | Gynecological | | |
| Vision/Eyes | | | Hospitalizations/Surgeries | | |

Describe any abnormalities or conditions listed above and the dates involved:

1. _____

2. _____

3. _____

This student is able to participate in all physical education activities. ☐ Yes ☐ No

If not, please describe: _____

_____

**Medications**

List any prescription or over-the counter medications the student takes on a regular or as-needed basis:

Name of medication: _____ Dose: _____ Times: _____

Purpose: _____

Name of medication: _____ Dose: _____ Times: _____

Purpose: _____

Name of medication: _____ Dose: _____ Times: _____

Purpose: _____

**Allergies**

Allergy to: Food: ☐ Yes ☐ No Medication: ☐ Yes ☐ No

Insect Stings: ☐ Yes ☐ No Environmental: ☐ Yes ☐ No

Describe allergen, reaction/symptoms and a treatment plan: _____

_____

Name of Physician: _____ Signature & Title: _____ Date: _____

*Physician Signature & Physician Stamp*

Office Telephone Contact: _____