



# MEDICAL RECORD AND AUTHORIZATION FORM



Passport  
photo  
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SIGNATURE OF PARENT/GUARDIAN

DATE:

## PUPIL

Name:

Surname

First name

Boy:

Girl:

Date of Birth:

date / month / year

## [SEN] SPECIAL EDUCATIONAL NEEDS

Does the pupil now (or in the past) have any special educational needs (e.g school support/referral to educational psychologist, doctor, specialist)?

- Yes  No If yes, (the school will ask you to present relevant assessment documentation):

## Has your child had any INJURY or SURGERY? \*

- |                             |                                 |                             |                                     |                              |   |
|-----------------------------|---------------------------------|-----------------------------|-------------------------------------|------------------------------|---|
| <input type="radio"/> Wrist | <input type="radio"/> Foot      | <input type="radio"/> Lungs | <input type="radio"/> Eyes          | <input type="radio"/> Hands  | <input type="radio"/> Head (concussion) |
| <input type="radio"/> Toes  | <input type="radio"/> Shoulders | <input type="radio"/> Ears  | <input type="radio"/> Fingers       | <input type="radio"/> Spine  | <input type="radio"/> Dislocations      |
| <input type="radio"/> Nose  | <input type="radio"/> Leg       | <input type="radio"/> Neck  | <input type="radio"/> Throat        | <input type="radio"/> Hip    | <input type="radio"/> Muscle strains    |
| <input type="radio"/> Back  | <input type="radio"/> Teeth     | <input type="radio"/> Knee  | <input type="radio"/> Arms          | <input type="radio"/> Hernia | <input type="radio"/> Ligament strains  |
| <input type="radio"/> Jaw   | <input type="radio"/> Ankle     | <input type="radio"/> Chest | <input type="radio"/> Osteomyelitis |                              |   |

## Does your child have any history of the following CONDITIONS?\*

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="radio"/> Diabetes               | <input type="radio"/> Blood in Urine       | <input type="radio"/> Nervousness     | <input type="radio"/> Rheumatic Fever    |
| <input type="radio"/> Bladder Problems       | <input type="radio"/> Kidney Problems      | <input type="radio"/> Asthma          | <input type="radio"/> Genital Problems   |
| <input type="radio"/> High Blood Pressure    | <input type="radio"/> Hay Fever            | <input type="radio"/> Tuberculosis    | <input type="radio"/> Persistent cough   |
| <input type="radio"/> Epilepsy (seizures)    | <input type="radio"/> Fainting Spells      | <input type="radio"/> Heart Problems  | <input type="radio"/> Arthritis          |
| <input type="radio"/> Consistent Cramping    | <input type="radio"/> Stomach (ulcer etc.) | <input type="radio"/> Anemia          | <input type="radio"/> Dizziness          |
| <input type="radio"/> Persistent Nose Bleeds | <input type="radio"/> Hepatitis            | <input type="radio"/> Ringing in Ears | <input type="radio"/> Migraine Headaches |
| <input type="radio"/> other...               |  |                                       |  |

## DETAILED MEDICAL HISTORY\*

- Is your child under a physician's care for any reason?  Yes  No
- Is your child taking any kind of medication?  Yes.  No.
- Has your child taken medication for emotional/behavioral problems such as ritalin for ADD/ADHD, Prozac for depression, Xanax for anxiety, etc.?  Yes.  No.
- Does your child have a history of emotional/behavioral problems?  Yes.  No.
- Is your child allergic to any food or medication?  Yes.  No.
- Does your child have any problems that limits his /her participation in athletics?  Yes.  No.
- Does your child have a hearing problem? If yes, does he/she wear a hearing aid?  Yes.  No.
- Does your child have trouble seeing? If yes, does your child wear glasses or contacts?  Yes.  No.

## List childhood diseases

(e.g. Chicken pox):

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\* If you have answered yes to any of the above questions please provide detailed explanations below and include instructions for medication if any:

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## IMMUNIZATION RECORD

Diphtheria Tetanus	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Pertussis	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Polio	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Measles/Mumps/Rubella	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
BCG Skin Test (TB)	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Hepatitis B	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Hepatitis A	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Japanese Encephalitis	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Typhoid	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Chicken Pox	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Small Pox	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Yellow Fever	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Influenza	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Tetanus	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>
Gamma Globulin	Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>	Date/Month/Year:	<input type="text"/>

## PREFERRED MEDICAL CLINIC

Name of clinic:

Address:

Tel. No:

Doctor's name:

## ALTERNATIVE/EMERGENCY CONTACT

<b>A</b>	Name:	<input type="text"/>	<b>B</b>	Name:	<input type="text"/>
	Relationship to Pupil:	<input type="text"/>		Relationship to Pupil:	<input type="text"/>
	Phone:	<input type="text"/>		Phone:	<input type="text"/>

## MINOR MEDICATIONS

I / We hereby authorise / do not authorise \* the school to administer minor medications (such as paracetamol) as deemed necessary by the school.

\* delete as appropriate

## EMERGENCY AUTHORISATION

I / We accept that whilst the school will make all reasonable efforts to contact us in case of medical emergency, this will not always be possible. Therefore, we authorise the school to seek advice and medical treatment and undertake to pay all costs incurred by the school.

## NOTE: Medical Costs

All medical costs are incurred by the parents or guardians.

Medical examinations conducted overseas are acceptable, however these records must be current within one year of this application.

# PHYSICAL EVALUATION

## TO BE COMPLETED BY A PHYSICIAN

Name:  Date of Birth:   
*day / month / year*

Height:  Weight:  Blood pressure / Pulse:

Vision: R 20/  L 20/  Corrected: Yes:  No:

Hearing:

## PHYSICAL EXAMINATION

Eyes/Ears/Nose/Throat:	<input type="text"/>	Neck:	<input type="text"/>
Lymph nodes:	<input type="text"/>	Back:	<input type="text"/>
Elbow/Forearm:	<input type="text"/>	Wrist/Hand:	<input type="text"/>
Lungs:	<input type="text"/>	Hip/Thigh:	<input type="text"/>
Abdomen:	<input type="text"/>	Leg/Ankle/Feet:	<input type="text"/>
Knee:	<input type="text"/>	Skin:	<input type="text"/>

Explain abnormal findings:

## PHYSICAL EXAMINATION RESULTS

Cleared for physical activity:

Not cleared for physical activity:

Reason:

NAME OF PHYSICIAN (print/type):

Facility:

Address:

Telephone:

Emergency contact:

Signature of Physician: \_\_\_\_\_ Date:   
*day / month / year*

## BIS Recognized Medical Facilities in Ho Chi Minh City

### **Australian Pathology**

38 Mac Dinh Chi St.,  
Dist. 1, HCMC  
827 2264, 827 2263  
acpd@hcm.vnn.vn

### **Columbia Saigon International Clinic**

8 Alexandre de Rhodes St,  
Dist. 1, HCMC  
823 8888, 823 8454  
columbia.asia.vn@hcm.vnn.vn

### **Centre Medical International**

1 Han Thuyen, Dist. 1, HCMC  
827 2366, 827 2365  
center-medic.inder@hcm.fpt.vn

### **Hong Duc Hospital**

234 Pasteur St., Dist. 3, HCMC  
829 3159  
hongduchosp@hcm.vnn.vn

### **Family Medical Practice**

Diamond Plaza, 34 Le Duan,  
Dist. 1, HCMC  
822 7848, 822 7859  
hcmc@vietnammedicalpractice.com

### **Franco-Vietnamese Hospital**

MD5-1 Saigon South, Tan Phu Ward,  
Dist. 7, HCMC  
411 3333, 411 3334,  
fvh@fvhospital.com

### **International SOS Clinic**

65 Nguyen Du St.,  
Dist. 1, HCMC  
829 8520, 823 6493  
jenny.williams@internationalsos.com