ST.PAUL AMERICAN SCHOOL HANOI

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Passport photo goes here

HEALTH CHECK UP

This form must be completed and returned to St. Paul Hanoi prior to school attendance. All the information must be in English.

STUDENT' S INFORMATION			
Full name of student:			
Gender: Female ☐		Male ☐	
Date of Birth (dd/mm/yy):			
Date of Examination:			

1. Height (cm)	**2. Weight**	**3. Urinalysis**

4. Allergies	No. ☐	Yes. ☐	Comments	
5. Asthma	No. ☐	Yes. ☐	Comments	
6. Current medication:	No. ☐	Yes. ☐	Comments	
7. Diabetes	No. ☐	Yes. ☐	Comments	
8. Epilepsy	No. ☐	Yes. ☐	Comments	
9. Fainting spells	No. ☐	Yes. ☐	Comments	
10. Bleeding disorders	No. ☐	Yes. ☐	Comments	
11. Autism	No. ☐	Yes. ☐	Comments	
12. ADHD/ADD	No. ☐	Yes. ☐	Comments	
13. Migraines	No. ☐	Yes. ☐	Comments	

CLINIC EVALUATION	**NORMAL**	**ABNORMAL**	**NOTES**
14. Hearing assessment			
15. Ears, Nose and Throat			
16. Mouth/Tongue (note speech problems)			

17. Abdominal Examination			
18. Cardinac system			
19. Respiratory system			
20. Skin (eczema/ dermatitis)			

21. EYES

Glass:	No ☐	Yes ☐		
Color blind	No ☐	Yes ☐		

Left eye vision :

Right eye vision:

Has the child has the following								
	Chicken pox	No ☐	Yes ☐					
	Measles	No ☐	Yes ☐					
	Mumps	No ☐	Yes ☐					
	Rubella	No ☐	Yes ☐					

PLEASE NOTE THE HISTOTY OF RELEVANT MEDICAL DETAILS CONCERNING CHILD

RECORD OF IMMUNIZATION

The following immunizations are COMPULSORY and UPDATED before 1ST DAY OF ADMISSION

VACCINE	DATE (DD/MM/YYYY)
POLIO	**1**
	2
	3
	4
	5
DIPTHERIA TETANUS PERTUSSIS	**1**
	2
	3
	4
	5

	1
MEASLES	**2**
MUMPS	**3**
RUBELLA	**4**
	5

EXAMINATION RESUTLS		
Recommendation for	**YES**	**NO (specify)**
Physical Education Activities		
Competitive activities		
Regular activities		
Restricted activities		
Date of examination:	Physician's name in print:	
(dd/mm/yy)		
Physician's Telephone number	Physician's signature and stamp:	