INTERNATIONAL SCHOOL OF AHAFO

MEDICAL EXAMINATION FORM

TO THE PARENT:

In order to ensure that we have up-to-date medical records on your ward, please complete this form and return to the School Office at your earliest convenience. This way, the school will be made aware of any medical condition or medication that is used in conjunction. The form should be completed and returned to the school even if there is no known condition. The information requested is strictly for providing care and will be treated with utmost confidentiality.

SECTION A: PERSONAL HISTORY:

Please complete in full and COMMENT ON ALL POSITIVE ANSWERS IN THE SPACE PROVIDED OR ATTACH A SEPARATE SHEET, if necessary.

Do you or have you ever had…?	Yes	No
Attention Deficit Hyperactivity Disorder (ADHD)/Learning Disability		
Anaemia/Blood Disorder		
Asthma/Wheezing		
Back Problems		
Cancer/Tumor		
Chest Pain/Shortness of Breath		
Counseling/Psychotherapy		
Dental Problems		
Diabetes		
Ear, Nose, Throat Problems		
Eye Problems		
Fainting/Loss of consciousness		
Fractures/Sprains/Dislocations		
Headaches		
Head Injury/Concussion		
Heart Disease		
High Blood Pressure		
Intestinal/Digestive Problems		
Kidney Disease/Bladder Infections		
Measles		
Mononucleosis		
Recent Weight Change/Eating Concerns		

PERSONAL HISTORY – Please complete in full.	
Medical & Dosage (regular or as needed)	
Hospitalization (date & diagnosis)	
Allergies to Medication	
Surgery (date & diagnosis)	
Reaction	
Allergies to Food	
Reaction	
Other Allergies	
What treatment is needed?	
Allergy Injections	
(Please attach detailed information from Physician)	

Jaundice/Hepatitis		
Mumps		
Pneumonia		
Rheumatic Fever		
Seizures		
Skin Problems		
Special Diet		
Sinusitis		
Significant Anxiety/Depression		
Thyroid/Hormone Problems		
Women Menstruation: Age of Onset		
Menstrual Problems		
Other Illness		

UNDERTAKING

I, ……,

Parent/ Guardian of

……

undertake to ensure that the required medical examinations are conducted to ascertain the health state of my child. I also confirm that the information is true to the best of my knowledge.

Signature:

Date:

If you answered yes to any of the above, please explain:

SECTION B: PHYSICAL EXAMINATION
(TO BE COMPLETED BY A PHYSICIAN)

TO THE PHYSICIAN: THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY. Please review the student's history and complete both sides of this page. Do include with this form a separate letter detailing the medical history and management plan for any serious or chronic illness, as well as medical test results for the following:

Student Name .....
Surname **Middle** **First**

Sex: M..... F .....

DOB: ...../...../.....

Right ..... Left.....

Hearing

Height .....

Vision - Uncorrected - Right .....

Weight ..... - Left .....

Blood Pressure ..... Corrected - Right ..... - Left .....

Blood Group .....

Pulse .....

Recommended

Urinalysis .....

Hematocrit/Hemoglobin .....

Are the following systems normal?	Yes	No	Findings
Skin			
Head, Eyes			
Ears, Nose, Throat			
Thyroid, Lymph Nodes			
Chest/Lungs			
Breasts			
Heart			
Abdomen			
Genitourinary			
Back/Extremities			
Neurological			
Psychological			

Allergies (medical): ……

……

Medications: ……

Is there loss or serious impaired function of any paired organ? Yes …… No……

Have there been any significant medical problems not noted above?……

Is there any reason to restrict activities?……

Do you recommend any further evaluation ? ……

Please send a detailed summary of any chronic illness or medical problem including treatment and recommendations.

COMPLETED MEDICAL EXAMINATION FORMS SHOULD BE RETURNED TO:

The Principal
International School Of Ahafo
Mensah Kumta Village, Newmont Ahafo Project
Ahafo Kenyase No. 1, Brong Ahafo Region
Tel: +233 (0) 540 866 760

SECTION C: VACCINATION RECORDS

Student's Name: _____D.O.B.: ___/___/___

The following inoculations should be administered as described below: Please indicate as Month/Day/Year. Alternatively, you are welcome to attach photocopies of your child's immunization records and skip the completion of the table below.

1. **Diphtheria/Pertussis/Tetanus:** 4 doses, provided 4th dose given on or after 4th birthday, and Td/Tdap booster every ten years thereafter.
2. **Polio:** 3 doses of all IPV or OPV, provided last dose given after 4th birthday, or 4 doses of any combination IPV/OPV.
3. **Measles/Mumps/Rubella (MMR):** 2 doses required; 1st dose after 12 months of age.
4. **Varicella:** One dose or history of disease.
5. **Hepatitis B:** Doses 1 and 2 separated by 28 days; dose 3 separated from dose 1 by 4 months minimum, 2 months from dose 2, on or after age 24 weeks.

IMMUNIZATIONS AND TUBERCULIN TEST:

Diphtheria/Pertussis/Tetanus: Completed primary series of DTP/DTaP/Td/Tdap.

Date of dose 1 _____ / _____ / _____
Date of dose 2 _____ / _____ / _____
Date of dose 3 _____ / _____ / _____
Date of dose 4 _____ / _____ / _____
Date of dose 5 _____ / _____ / _____

Booster (must be within last 10 years)
Date: _____ / _____ / _____

☐ Td ☐ Tdap

Polio: Completed primary series as above._#
Date of dose 1 _____ / _____ / _____ OPV/IPV circle one
Date of dose 2 _____ / _____ / _____ OPV/IPV circle one
Date of dose 3 _____ / _____ / _____ OPV/IPV circle one
Date of dose 4 _____ / _____ / _____ OPV/IPV circle one

HPV Vaccine: *(highly recommended)*
Gardasil ___ Other ___
Date of dose 1 _____ / _____ / _____
Date of dose 2 _____ / _____ / _____
Date of dose 3 _____ / _____ / _____

Measles/Mumps/Rubella (MMR):
Date of dose 1 _____ / _____ / _____
Date of dose 2 _____ / _____ / _____

Tuberculin Test: (PLEASE COMPLETE THIS SECTION IF INDICATED BY TUBERCULOSIS SUPPLEMENT)
TB Skin Test Date: _____ / _____ / _____

Result _____ mm induration If positive skin test: Date of chest x-ray ____ / ____ / ____ Medication _____ (over 10mm in duration) Result _____Date Started ____/____/____ duration _____ month _____ Previous BCG: Date ____/____/____ Quantiferon/IGRA test: Date: _____ Result _____	
Hepatitis B (*required*) Date of dose 1 _____ / _____ / _____ Date of dose 2 _____ / _____ / _____ Date of does 3 _____ / _____ / _____	**Hepatitis A** *(recommended)* Date of dose 1 _____ / _____ / _____ Date of dose 2 _____ / _____ / _____
Other Immunizations:	

PHYSICIANS:

- Students are required to have a current TB test. If test is positive, (greater than 10mm in duration) we recommend a quantiferon/IGRA. **If this is positive and TB infection is confirmed by X-ray, then we recommend that the applicant be kept at home for treatment and support**.
- Please make certain **all immunizations** meet our requirements. Specify history of measles, mumps, rubella and chicken pox immunizations.

DECLARATION:

I declare that I have examined the student and that this is a true and correct record of my findings.

Place of Examination:		**Physician's Signature and Stamp**	
Postal Address		**Date**	
Contact Telephone		**Full Name**	
Email Address			