



"DPS INTERNATIONAL SCHOOL'RVG0NVF0

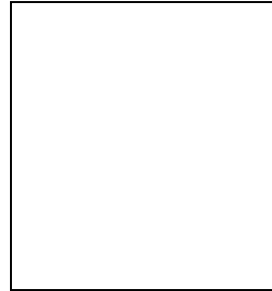
36 Aroozoo Avenue (near Charlton Park) Singapore 539842
Tel: (65) 62856300 Fax: (65) 62948195 Website: www.dps.edu.sg

MEDICAL EXAMINATION FORM

Name: _____
Last(family) First(given) Middle

Sex: M/F

Birthdate: _____ Age _____ Grade _____
Month/Day/Year



Name of Parent / Guardian:
 Mother: _____
 Father: _____
 Guardian: _____ Relationship: _____
 Telephone(Home): _____
 Mother's Office: _____
 Father's Office: _____

Family Physician in Singapore
 Address: _____

 Telephone: _____
 Emergency Contact: _____
 Telephone: _____ Mobile: _____

Height: _____ Weight: _____ Blood Group: _____ B/P: _____ Heart Rate _____

Alleries: _____

CURRENT MEDICATION	DOSAGE	PURPOSE

	NORMAL	ABNORMAL	REMARKS
Head			
Eyes			
ENT			
Dental			
Chest			
Heart			
Abdomen			
Genitalia			
Skin			
Extremities			
Spine			

Competitive Sports participation approved: Yes / No

TO BE FILLED OUT BY THE PHYSICIAN
HEALTH HISTORY: "X" mark Yes or No

	YES	NO
Chronic/recurrent illness		
Hospitalisations		
Surgery		
Injury treated by physician		
Organ missing		
Heat exhaustion/stroke		
Dizziness/fainting/headaches		
Convulsions/fits		
Concussion		
Wears glasses/contacts		
Dental caps/bridges/braces/plates		
Asthma		
Problem with heart/murmurs		
Problems with spleen/liver		
Problems with bladder kidneys		
Hernias/GI problems		
Bone/joint injury		
Sprain/dislocation		
Learning Disorder		
Congenital Disorder		
Behavioral Disorder		

SUMMARY: Explanation of "Yes" answers Physicians Comments/ Follow Ups

For further details, please attach additional sheets.

IMMUNIZATION HISTORY						
Fill in the dates Immunization given						Remarks
Diphtheria, Pertussis						
Tetanus						
Polio						
Measles						
Mumps						
Rubella						
Hepatitis B						
Hepatitis A						
Typhoid						
TB/PPD						
Chicken Pox						
Others						

All prescription medications need a written note from the parent/guardian. All medications along with the note must be submitted to the school nurse. Medications need to be in the original pharmacy physician containers and marked with the patients name, name of drug, dosage, schedule & instruction. Students are not allowed to be carrying

any prescription/controlled medication (such as Ritalin, pain killer pills, antibiotics, etc) in their personal belongings while at school.

Emergency Treatment Authorization: In the event of an emergency when immediate observation or treatment is deemed necessary in the judgment of the school nurse/authorities, I authorize and direct the school authorities to send my child to the medical facility most readily accessible.

Permission to administer Panadol/Tylenol(Acetmetaphen)

YES

NO

Parent / Guardian Signature

Date

IT IS THE RESPONSIBILITY OF THE PARENT / GUARDIAN TO NOTIFY THE SCHOOL NURSE IN WRITTEN OR CHANGES IN THE INFORMATION GIVEN IN THE FORM E.G. CHANGE IN ADDRESS, TELEPHONE NUMBER.