BANGKOK GRACE INTERNATIONAL SCHOOL

79/3-12 Ladphrao Soi 112, Wanthonglang, Bangkok, Thailand 10310
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NEW STUDENT HEALTH DATA

STUDENT ID _____ (to be filled up by Admin Officer) Date: _____

A. GENERAL INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Nationality _____

Current Address _____ Permanent Address _____

Home Phone _____ Email Address _____

Mobile Phone _____

In case of EMERGENCY, Please contact _____
Telephone No. _____
Relationship _____

SEX		AGE		HEIGHT		WEIGHT		BLOOD TYPE	
	M/F		Year		cm.		kgs.		

B. RECORD OF MEDICAL EXAMINATION

B.1 PHYSICAL EXAMINATION (by a Physician)

GENERAL CONDITION _____ NOSE_____ THROAT_____
HEART_____ BLOOD PRESSURE _____ ABDOMEN_____
LUNGS_____ GLANDS_____RIGHT EAR_____ LEFT EAR_____
RIGHT EYE _____ LEFT EYE _____ COLOR BLINDNESS_____
* NEED GLASSES ( ) CONTACT LENSES ( )
* POWER; RIGHT EYE _____ LEFT EYE _____

B.2 DENTAL CHECK (by a Dentist)

FINDINGS_____

RECOMMEDATION _____

SIGNATURE OF DENTIST_____

B.3 COMPLETE BLODD COUNT (Laboratory Findings)

(NOTE: Students under twelve years are required only the test for BLOOD TYPE)

BLOOD GROUP _____ HB _____gm% WBC_____cell/mm
PMN _____% L_____% M_____ % E _____% B _____%

B.4 URINARLYSIS (Laboratory Findings)

SP. GR._____ PH_____ ALBUMIN _____SUGAR _____
MICROSCOPIC: RBC_____/HPF WBC _____ /HPF

B.5 STOOLALANYSIS (Laboratory Findings)

OVAPARASITE _____

C. PAST IMMUNIZATION RECORD

(To be completed by the doctor or the parent)

DISEASE	YES	NO
	(Please check)	
DPT(Diphtheria , Whooping, Cough, Tetanus)		
Poliomyelitis		
Measles + Rubella + Mumps (MMR)		
BCG (Tuberculosis)		
Typhoid		
Cholera		
Hepatitis A		
Hepatitis B		
Japanese B Encephalitis		
Other (Please describe)		

SUMMARY OF DEFECTS, DIAGNOSIS, AND RECOMMENDATION

_____

_____

_____

_____

_____

_____

Date _____ Signature of Physician/Seal of Hospital _____

I certify that all the information given above is complete and correct.

Date _____ Signature of Parent / Guardian _____