**39 Yeonhui-ro 22-gil, Seodaemun-gu**
**Seoul, Korea 03723**
**Tel: (82-2) 330-3203**
**Fax: (82-2) 333-5027**
**E-mail: sfsnurseoffice@seoulforeign.org**

***Please return this form to Health Office PRIOR TO the student's start date at SFS.***

# Part II – Report of Medical Examination

*This page needs to be filled out by a **PHYSICIAN**.

Student's Name: Last_____, First_____Middle_____

Date of Birth (mm/dd/yr): _____/_____/_____ Grade/Year _____

Height_____cm Weight_____kg Blood Pressure_____/_____(ONLY for students age 11 and older) Pulse_____

Vision: R _____ L _____ Both _____ Corrective Lens: ☐ Yes / ☐ No

| **NOTE: Please administer the following REQUIRED tests.** | Date (mm/dd/yr) | Result |
|---|---|---|
| **Tuberculosis Skin Test OR Chest X-ray OR TB blood test (IGRA)** (NOTE: If TB skin test result is positive, either chest X-ray or TB blood test (IGRA) is required regardless of previous BCG vaccination.) | | TB skin test:<br>Chest X-ray:<br>TB blood test (IGRA): |
| **Hemoglobin** (Students under 5 years of age are exempt from this test.) | | |
| **Urinalysis** (Students under 3 years of age are exempt from this test.) | | |

| | Normal | Abnormal | | Normal | Abnormal |
|---|---|---|---|---|---|
| Ears/Hearing | | | Musculoskeletal | | |
| Nose | | | Spine | | |
| Mouth | | | Skin | | |
| Throat | | | Neurological | | |
| Neck | | | Nutritional | | |
| Heart | | | Emotional/Psychological | | |
| Lungs | | | Behavior | | |
| Abdomen | | | Speech | | |

**Physician's Comments:**

Please list any medication the student takes on a regular basis.
**NOTE: A separate medical form (Part III) is required for all medication and treatment to be administered at school.**

| Name of Medication | Purpose | Dose/Time |
|---|---|---|
| | | |

» **This student is physically able to participate in all physical education and sports activities: ☐ Yes / ☐ No**

If NO, please explain:

_____

**NOTE TO THE PHYSICIAN:** SFS follows the U.S. CDC immunization schedule. Please help us ensure this student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio & MMR at age 4-6 and DT/Td/Tdap at age 11-12. Immunization record is on a separate form (Part I - 3). If immunization is administered, please complete the form. Thank you.

** Please note that SFS does NOT accept a student's physical exam certified by a parent who may be a physician or medical professional.*

| **Physician Signature** | **Date of Examination (mm/dd/yr)** |
|---|---|
| **Printed Name** | **Clinic Name & Phone Number** |