STAMFORDAMERICAN
International School

Medical Examination Form

- This form is **REQUIRED** for all applications to Stamford American International School and must be signed by a parent **BEFORE** a student attends classes or participates in any activities.
- This form may be completed in your home country but must be for the current school year (completed no earlier than six months prior to the start of school).
- Stamford reserves the right to withhold a student from classes until this form is completed in full and returned to the Admissions Office.

Please attach photo here

TO BE FILLED OUT BY A PHYSICIAN

Name: _____ Sex: Male / Female
Last (family) *First (given)* *Middle*

Birth Date: _____(dd/mm/yyyy) Age: _____ Grade: _____

HEALTH HISTORY: Has the student experienced any of the following in the past? Please mark "X" to indicate Yes or No

	Yes	No
Chronic/recurrent illness		
Hospitalizations/surgery		
Other (ADHD, Autism, etc.)		
Injury treated by physician		
Congenital abnormality		
Heat exhaustion/stroke		
Dizziness/fainting/headaches		
Concussion		
Eyes:related conditions/wears glasses/contacts		
Dental caps/bridges/braces/plates		
Cardiac abnormalities/ heart/murmurs		
Problems with bladder/kidneys		
Skin eg Eczema		
Skeletal(fractures, dislocations/sprains/scoliosis)		

ALLERGIES: _____

Height: _____ Weight: _____

B/P: _____ Heart Rate: _____

Current Medications	Dosage	Purpose

	Normal	Abnormal	Remarks
Head			
ENT			
Chest			
Abdomen			
Genitalia			

Summary: If you answered *Yes* to any of the above, please provide details:

_____

_____

_____

Sports Participation Approved? Yes No

Limitations:

_____

Physician Signature/Stamp/Date

Competitive Sports Participation Approved? Yes No

☐ Immunization current for age as certified by a physician

IMMUNIZATION HISTORY: _____ (name of student)

Copies of records may be submitted. Parents or physician to transcribe on this form please.

	Fill in the Dates Immunizations Given					Remarks
Diphtheria						
Tetanus						
Polio						
Pertussis						
Measles						
Mumps						
Rubella						
Hepatitis A						
Hepatitis B						
Pneumococcal						
Haemopholus Influenza (Hib)						
OTHER						
Meningococcal						
Chicken Pox						
BCG						
Typhoid						

TO BE FILLED OUT BY PARENTS

Name of Parent/Guardian:

Mother _____

Phone _____

Email _____

Father _____

Phone _____

Email _____

Family Physician in Singapore:

Name _____

Phone _____

Emergency Contact Name *(non parent)* _____

Relationship _____

Phone _____

If the student requires medication to be given during school hours please complete a 'Request to Administer Medication Form'. All medications along with the form must be submitted to the School Nurse. Medications need to be in the original pharmacy/physician containers and marked with the student's name, name of drug, dosage, schedule and instructions. All information must be in English. Students are not permitted to be carrying any medication in their personal belongings while at school.

If the student has significant allergies requiring emergency medications or if the student has a medical diagnosis requiring the nurse's attention, please contact the school to set up an appointment to meet with the School Nurse prior to the student's commencement at Stamford.

Permission to Administer Paracetamol (Please circle): Yes No

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 available.

_____ _____

Parent / Guardian Signature *Date*

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL IN WRITING OF ANY CHANGES TO THE INFORMATION GIVEN IN THIS FORM e.g. changes of address, telephone number, physical condition or medications.

School Nurse: +65 6602 7216 **nurse@sais.edu.sg**