2005-2006 MEDICAL RECORD - THE AWTY INTERNATIONAL SCHOOL

(Each required section should be completed and a U.S. Physician must sign and date this form.)

NAME : _____ DATE OF BIRTH : _____ GRADE : _____
(Mo. / Day / Yr.) 2005-2006

- **PHYSICAL EXAMINATION** [Required for ALL NEW STUDENTS only, grade PK3 through 12th.]

Current Height _____ Current Weight _____ Blood pressure _____ Respiratory rate _____ Pulse _____

- **SPINAL SCREENING** [Required for ALL NEW students. ALSO Required of all students entering grades 6th (6ème) and 9th (3ème)]

Passed _____ Failed_____ Follow-up _____ Referred _____
Comments: _____
Screener's Name _____ Signature _____ Date _____

- **VISION SCREENING**

[Required for ALL NEW students. ALSO Required of all students entering grades PK4, K, 1st (CP), 3RD (CE2), 5th (CM2), 7th (5ème) and 9th (3ème)]

Right eye 20/_____ Left eye 20/_____ Passed _____ Failed _____ Follow-up _____
Wears glasses: Yes ___ No ___ Wears contact lenses: Yes ___ No ___
Comments: _____
Screener's Name _____ Signature _____ Date _____

- **HEARING SCREENING**

[Required for ALL NEW students. ALSO Required of all students entering grades PK4, K, 1st (CP), 3RD (CE2), 5th (CM2), 7th (5ème) and 9th (3ème)]

Right ear: Passed _____ Failed_____ Follow-up _____ Referred _____
Left ear: Passed _____ Failed_____ Follow-up _____ Referred _____
Comments: _____
Screener's Name _____ Signature _____ Date _____

- **DIABETES SCREENING-**(Acanthosis Nigricans)

[Required for ALL NEW students. ALSO Required of all students entering grades 3RD (CE2), 5th (CM2), 7th (5ème)]

Passed ____ Failed_____ Blood Pressure_____ BMI_____ Weight_____ Follow-up _____ Referred _____
Comments: _____
Screener's Name _____ Signature _____ Date _____

TB Test (Mantoux) (**ALL NEW STUDENTS** must provide evidence of a negative skin test having been given in the USA and within the last twelve months. BCG or a recent Monotest are NOT accepted.)

Date Read: _____ Negative _____ Positive _____ Signature of Reader: _____

Chest X-ray for Positive TB test: Date _____ Negative □ Positive □ *(A copy of the chest x-ray report must accompany this form)*

Antibiotic Therapy started after positive TB test? Yes _____ No _____

IMMUNIZATION REQUIREMENTS FOR ALL STUDENTS

New Students- **Please attach a current copy of your child's immunization record to this form.**
Returning Students- **You must submit updated immunization records with each new vaccine obtained**

DTP/DTaP	**Everyone must complete this part of form**
Polio	***Varicella (chickenpox)-** vaccine date_____**(mandatory August 2000)**
HIB	
Measles	
Mumps	This is to verify that _____had varicella disease(chickenpox)on
Rubella	Student name
M M R	Or about _____and does not need varicella vaccine.
***Varicella [Chicken Pox]**	Month/day/year
Hepatitis A (optional)	
Hepatitis B	_____ Physician or Parent signature

I certify that on this date _____I have examined the above mentioned student and find that he/she is □ is not □ in good health, is free of contagious disease and is up to date on all immunizations required by the State of Texas.

Doctor's Name _____ Signature _____ Phone Number_____
PRINT NAME