

**Welltain Christian International School**

Cheongyeon Plaza 6th Floor, Jungbong-daero 586 beon-gil 15, Seogu, Incheon, Republic of Korea

•Phone: (+82)10-8224-1468

(+82)10-9087-2929

•E-mail: [admissions @welltaincis.org](mailto:ooo@welltaincis.org)

•Website: [www.welltaincis.com](http://www.welltaincis.comg)

**Medical Examination Form**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ Grade: \_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO THE PHYSICIAN:**

Please make a physical examination of the student named above.

YES NO

**□**

**□**

**□**

**□**

**□**

**□**

**□**

**□**

**□**

**□**

Menstrual Cycle

Musculoskeletal

Metabolic/Endocrine

Neuropsychiatric

Pelvic

Respiratory

Skin

Teeth and Gums

Other

YES NO

**□**

**□**

**□**

**□**

**□**

**□**

**□**

**□**

YES NO

**□**

**□**

**□**

**□**

**□**

**□**

**□**

**□**

**□**

**□**

Cardiovascular System

Ears, Nose, Throat

Eyes

Gastrointestinal

Genito-Urinary System

1. Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Does the student wear contact lenses? **□** Yes **□** No 5. Does the student wear glasses? **□** Yes **□** No

6. Are there any current abnormalities in the following systems? If **YES**, please provide additional information.

7. Is the student currently under treatment for any medical or emotional conditions? If “**YES**” please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Does the student have an eating disorder or a history of eating disorder? If “**YES**” please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Your personal opinion on the student’s state of health: **□** EXCELLENT **□** GOOD **□** FAIR **□** POOR

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Is the student taking any medication (oral or injection) on a regular basis? If “**YES**” please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Is the student taking any medication for intermittent or emergency use? If “**YES**” please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. **PHYSICAL ACTIVITIES**: (Normal Physical Education Classes: swimming, soccer, basketball, etc.)

**□** Unrestricted **□** Restricted (Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Vaccination**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine** | Vaccination Date | | | | |
| 1st | 2nd | 3rd | 4th | 5th |
| Chicken Pox, Polio (TOPV-Tri-Oral-Polio-Vaccine) |  |  |  |  |  |
| Diphtheria, Whooping Cough &Tetanus (DPT) |  |  |  |  |  |
| Or Tetanus & Diphtheria only (TD) |  |  |  |  |  |
| Mumps |  | Some vaccines are available in combination with others such as measles & rubella (M-R) & measles, mumps & rubella (M-M-R). If a student received any combined vaccine, enter the date in each appropriate box, | | | |
| Measles |  |
| Rubella |  |
| Hepatitis A |  |  |  |  | |
| Hepatitis B |  |  |  |
| Tetanus Booster (Age 14-16yrs) |  |  |  |
| Tuberculosis (BCG) |  |  |  |  |  |
| Other Inoculations: |  |  |  |  |  |

Doctor’s Name (Capital Letters): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Examination: \_\_\_\_\_\_\_\_\_\_\_\_