International Physical Examination Report Part 1 *(to be completed by student/parents)*

Student's First Name | Middle Initial | Family Name | Date of Birth (Month/Day/Year)

Address | City | State | Postal Code | Country

Medical History

*Have you had or do you have? **Please mark each item yes or no.***

	Yes	No		Yes	No		Yes	No
Measles			Eating Disorder			Epilepsy/Seizure Disorder		
Mumps			Sexually Transmitted Disease			Diabetes		
Rubella			Strokes			Rheumatic Fever/Heart Disease		
Chicken Pox			Tuberculosis			Hernia		
Asthma			Broken Bones			Malaria		
Appendicitis Chronic			Cancer			Concussion or Head Injuries		
Enuresis			Vertigo/Dizziness			Parasites		
Thyroid (Goiter, Struma)			Hepatitis			Sleepwalking		

Have you ever been hospitalized, had surgery, or been under extended medical care? If yes, for what reason?

____

____

____

List medications taken regularly:____

Do you wear braces or require specialized dental or orthodontic care? ________________________________

Student Name: ___________________________________

Systemic Review: Do you have any of the following? (Check Each Item)

	Yes	No		Yes	No		Yes	No
Ears, Eyes, Nose, Throat			Hearing Problems	○	○	***Neck***		
Eye Disease or Injury	○	○	Do You Wear Hearing Aids?	○	○	Stiffness	○	○
Do You Wear Glasses?	○	○	Dizziness	○	○	Thyroid Trouble	○	○
Double Vision	○	○	Episodes of Unconsciousness	○	○	Enlarged Glands	○	○
Headaches	○	○						
Glaucoma	○	○	***Skin***			***Respiratory***		
Nosebleeds	○	○	Skin Disease, Hives, Eczema Jaundice	○	○	Spitting Up Blood	○	○
Chronic Sinus Trouble	○	○	Frequent Infection or Boils	○	○	Chronic Cough	○	○
Ear Disease	○	○	Abnormal Pigmentation	○	○			

If you checked "yes" for any of the above, a physician must provide full details (use additional sheet if needed):

____

Allergies and Sensitivities (Check Each Item)
Is there a history of skin reaction, other reaction or sickness, or anaphylaxis following injections or oral administration of:

	Yes	No		Yes	No
Penicillin or other antibiotics	○	○	Tetanus, Antitoxin or Other Serums	○	○
Morphine, Codeine, Demerol or Other Narcotics	○	○	Any Foods (i.e. Eggs, Milk, Chocolate)	○	○
Aspirin, Empirin or Other Pain Remedies	○	○	Pets/Animals	○	○
Other:____				○	○

If you checked "yes" for any of the above, please list or explain (Use additional sheet if needed) ____________________

____

Neuro-Psychiatric (Check Each Item)

	Yes	No
Have you ever had challenges with stress, anxiety, or depression?	○	○

Student Name: ___________________________________

If yes, have you sought help for this issue in the form of therapy or counseling?	○	○

When under stress or feeling anxious, what has helped you to cope?

____

____

INTERNATIONAL PHYSICAL EXAMINATION REPORT PART 2: (*To be completed by **attending physician** within the past 3 months*)

Clinical Evaluation (Check Each Item)

	Normal	**Abnormal**		**Normal**	**Abnormal**
Head, face, neck, scalp	○	○	Endocrine System	○	○
Nose	○	○	G-U System	○	○
Sinuses	○	○	Upper Extremities	○	○
Mouth and Throat	○	○	Feet	○	○
Ears – general	○	○	Lower Extremities	○	○
Drums (perforated)	○	○	Spine	○	○
Eyes	○	○	Body Marks, Scars	○	○
Ophthalmoscopic	○	○	Tattoos	○	○
Pupils	○	○	Skin, lymphatics	○	○
Ocular Motility	○	○	Neurologic	○	○
Lungs and Chest	○	○	Psychiatric	○	○
Heart	○	○	Pelvic (female only)	○	○
Vascular	○	○	Abdomen and viscera	○	○

Measurements and Physical Description

Height Weight Hair Color Eye Color Build (Slender, Medium, Heavy)

Blood Pressure

Sitting Recumbent Standing

Pulse (arm at heart level)

1) Sitting 2) Immediately after Exercise 3) 2 Minutes after Exercise 4) Recumbent after Standing 3 Minutes

Laboratory Results

Tuberculosis (Clearance must be within 6 months) ***Skin Test:*** Date_____________ Positive Negative

Student Name: ___________________________________

If positive, X-ray date, results and treatment MUST be provided.

Signatures

Type or Print **Physician** Name

Address City State Country Phone/Fax

Signature of **Physician** Date of Exam

We certify that the information supplied is true and complete to the best of our knowledge. We authorize any of the doctors, hospitals, or clinics mentioned above or attached to furnish a complete transcript of medical records for purposes of processing this application.

Signature of **Student** Date

Signature of **Parent** Date