Student Name:_____ Registration no._____ Grade:_____

BRANKSOME HALL ASIA
INTERNATIONAL SCHOOL FOR GIRLS

Physical Examination Form 신체 검사표

This form is to be completed and signed by your physician.
이 표는 주치의/의사가 작성하고 서명해야 합니다.

Student Name 학생이름: _____

Date of Birth 생년월일: _____
Day(일) Month(월) Year(연도)

Height 키: _____ Weight 체중: _____

BP 혈압: _____ Pulse 맥박 : _____

Hemoglobin result 헤모글로빈 수치: _____

General Health: Please check any areas of concern and describe in the space provided below:
건강상태: 염려되는 부분에 체크하시고 내용은 아래에 자세히 기재해 주시기 바랍니다.

☐ Head and neck(머리/목) ☐ Joints(관절) ☐ EENT(이비인후) ☐ Vision(시력)

☐ Back(등) ☐ Chest(가슴) ☐ Endocrine(내분비) ☐ Hearing(청력)

☐ Gastrointestinal(위장) ☐ Reproductive system (생식기관) ☐ Heart(심장) ☐ Speech(언어능력)

☐ Psychological/Emotional(정신적/감정적)

Other 기타:

_____

_____

_____

Will the student need follow-up care with a specialist while at Branksome Hall Asia? ◯ Yes ◯ No
학생이 브랭섬 홀 아시아에 있는 동안 계속적인 간호를 필요로 합니까?

If yes, please specify "예"인 경우 구체적인 내용을 기재해 주시기 바랍니다:

_____

_____

_____

Please list any medications currently taken by the student and indicate when they were started:
학생이 현재 복용중인 약이 있다면 복용을 시작한 시기와 함께 적어주시기 바랍니다.

_____

_____

_____

Please list all known CONFIRMED allergies and provide a letter stating the type of reaction of ingested or exposed to any of the following:
알고 계신 모든 확인된 알레르기를 적어주십시오. 아래 중 어떤 것에라도 그것을 먹었거나 혹은 그것에 노출되었을 때 나타나는 반응에 대해 자세히 적어주십시오.

Foods 음식: _____

Medications 약: _____

Other 기타: _____

Does she require an epipen? Yes ◯ No ◯
알레르기 쇼크 응급주사를 필요로 합니까?

Please list any previous surgeries or hospitalizations 과거의 수술이나 입원경력을 적어주십시오:

_____

_____

Has this student had Chicken Pox? ◯ Yes ◯ No
학생이 수두에 감염된 적이 있습니까?
If no, has she been immunized against Chicken Pox? ◯ Yes ◯ No Date: _____
아니라면, 수두에 면역력이 있습니까?
Has this student had Hepatitis B? ◯ Yes ◯ No
학생이 B형 간염에 감염된 적이 있습니까?
If no, has she been immunized against Hepatitis B? ◯ Yes ◯ No Date: _____
아니라면, B형 간염에 면역력이 있습니까?

Please attach a copy of blood test results of immunity to Chicken Pox and Hepatitis B.
수두와 B형 간염에 대한 면역이 명시된 혈액검사 결과를 첨부해주시기 바랍니다.

I have examined _____

Student's Last name 학생의 성 First name 이름

and find her to be in good health and fully capable of participating in the athletic and co-curricular programs at Branksome Hall Asia.
이 학생의 건강상태는 양호하며 브랭섬 홀 아시아에서 수행하는 체육과 방과후 활동에 충분히 참가할 수 있습니다.

Signature of physician 담당의 서명: _____

Date 작성일: _____

Day(일) Month(월) Year(연도)

Address 주소:

Telephone 전화번호: _____

Under the Personal Information Protection and Electronic Documents Act(PIPEDA), Branksome Hall Asia is committed to protect the personal information of all our constituents. All information collected on this form is in accordance with the Branksome Hall Asia Privacy Policy, available at www.branksome.asia

Email: admissions@branksome.asia

Student name: Last_____, First_____ Student ID:_____Grade __

Immunization Requirement

- Please help us ensure the student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio & MMR at age 4-6 and Tdap at age 11-12.

- **Please PRINT the exact dates (mm/dd/yr) of vaccinations received.**

Immunization Records					
Type of Vaccine	**1st Dose mm/dd/yr**	**2nd Dose mm/dd/yr**	**3rd Dose mm/dd/yr**	**4th Dose mm/dd/yr**	**5th Dose mm/dd/yr**
DPT/DTaP: Diphtheria, Tetanus, & Pertussis	2 months	4 months	6 months	15-18 months	4-6 years
Tdap: Tetanus, Diphtheria, & Pertussis	11-12 years				
Polio	2 months	4 months	6-18 months	4-6 years	
MMR: Measles, Mumps, & Rubella	12-15 months	4-6 years			
Hepatitis B	#1	#2	#3		
Varicella: Chicken pox OR Disease History	12-15 months	4-6 years	**Disease History**		

Tuberculosis Screening

All students enrolled at BHA are required to have either PPD skin test OR chest X-ray every other year.

Test Performed (circle one)	**Date** (mm/dd/yyyy)	**Result**
PPD skin test OR Chest X-ray		PPD skin test: Chest X-ray:

Please Note:

If PPD skin test result is positive, a chest X-ray is required.

A BCG vaccine does not exempt a student from completing the TB requirement to attend BHA.

Physician Signature	Date of Examination(MM/DD/YR)
Physician's Printed Name	Clinic Name & Phone Number