The Overseas School of Colombo

Medical Report

Student's Name: ..... (Last Name) ..... (First Name) Grade: .....

Medical Examination By Physician

Development: Weight : ..... Height : .....

Comments:

Eyes: Vision Right : ..... Left : .....

Does the Student wear glasses? Yes ☐ / No ☐

Ears: Hearing .....

Is there evidence of ear infections? Yes ☐ / No ☐

Teeth: Permanent : ..... Deciduous : .....

Nose: .....

Throat: Lymph Nodes .....

Lungs: .....

Heart: Size Murmurs: .....

Abdomen: .....

Genital: .....

Extremities: .....

Posture and Spine: .....

Reflexes: .....

Urine: ..... Albumen : ..... Sugar : .....

Blood: Hb .....

Blood Group & Rh Factor A B O AB Rh

Blood Pressure: .....

TB Skin Test: Type: ..... Date: ..... Result: .....

BCG Vaccine: ..... Date: .....

Recommendations for physical activity

☐ Full physical activity

☐ Modified physical activity because of:

Medical History

Mark the relevant medical concerns.

☐ Allergies ☐ Asthma ☐ Congenital ☐ Anomalies
☐ Convulsions ☐ Epilepsy ☐ Diabetes
☐ Recurring Ear Infections ☐ Hearing Difficulties
☐ Frequent Headaches ☐ Heart Problems ☐ Kidney
☐ Urinary Infections ☐ Menstrual Problems
☐ Orthopedic Problems ☐ Post-operatic Condition
☐ Rheumatic Fever ☐ Skin Problems
☐ Tuberculosis ☐ Visual Problems ☐ Other.

Please comment .....

Medication:

Is the student on medication? Yes ☐ / No ☐
Does the student take it himself Yes ☐ / No ☐
Please list the name of the medication and frequency.

.....

The school doctor is allowed to administer medicine and inform parent/guardian as deemed necessary. Yes ☐ / No ☐

Immunizations: Please note that the following immunizations are required by OSC

Date of last booster: : .....
Diphtheria/Tetanus/ Pertussis : .....
Tetanus (every 10 years) : .....
Typhoid (three years) : .....
Mumps : .....
Oral polio : .....
Measles : .....
Rubella : .....
Other

Residence: ..... Office: .....

Emergency Contact No.

Permission is hereby given for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified.

Declaration:

I certify that all information given is complete and correct.

..... Signature of Physician ..... Date ..... Signature of Parent ..... Date