MEDICAL REPORT

To be completed and signed by a medical physician. This form should be completed in **English only**.

To the Physician: This individual has been nominated as a scholar to study the two-year International Baccalaureate Diploma Programme at Li Po Chun United World College, in Hong Kong. The UWC experience can ask a lot from the student both physically and mentally. Thus, it is necessary for us to seek a professional evaluation of the student's physical and mental health.

The report will be kept **confidential** and are shared only with the school nurse, the appointed medical physician, and if required, with appropriate staff members.

PART 1 PERSONAL INFORMATION (To be completed by the parent/guardian.)

Student's Surname: _____ Given Names: _____

Sex: Male/Female Date of Birth (dd/mm/yy): _____

Parent / Guardian's Name: _____

Home Address: _____

E-mail address: _____ Home Telephone: _____

Tel. For Emergency Contact: _____

Do you have health insurance in Hong Kong? Yes/No

If Yes, does this include:

Hospitalization	Yes	No
Outpatient service	Yes	No
Dental	Yes	No
Prescription medications	Yes	No
Counsellor or psychologist	Yes	No

* Parents/Guardians are responsible for all dental expenses and prescription medications.

PART 2 MEDICAL CONDITIONS (To be completed and signed by a medical physician.)

Physical health

Height _____cm Weight _____kg

Blood Pressure _____mmHg Pulse _____/min

Ear Nose Throat _____ Abdomen _____

Locomotor System _____ Central Nervous System _____

Respiratory System _____ Cardiovascular System _____

Investigation of other conditions _____

Laboratory reports

1. Chest X-Ray: must be taken within recent six months, Date: _____

   X-Ray report: _____

2. Urine (full & microscopic examinations):_____

3. Blood test:

   Haemoglobin _____ Date: _____

   Hepatitis B screening:

   HBsAg _____ Date: _____

   HBsAb _____ Date: _____

   Hepatitis B is quite common in Hong Kong and in order to give suitable advice to students it is important for us to know whether a student is a carrier or not.

Immunisation records

(A) Required Immunizations

ALL students must present documentary evidence of immunisation. Incomplete documentation regarding immunisation will require a student to have a complete primary series of immunisation. In addition, please complete the record below:

	Date of Immunisation (dd/mm/yy)	Date of Booster (dd/mm/yy)
Tetanus		* on or after the ages of eleven
Hepatitis B		N.A.
MMR		N.A.

(B) Recommended Immunizations

Students will travel to South East Asia during Project Week, the following vaccinations are recommended for travel to some countries in South East Asia.

	Date of Immunisation (dd/mm/yy)
Typhoid	
Meningococcus	
Hepatitis A	

Have you had Chicken Pox before: ❑No ❑Yes, date: _____

If No, you are encouraged to have Chicken Pox vaccination.

❑ 1st dose. Date: _____ ❑ 2nd dose. Date: _____

Mental health

Please tick all that apply.

Has the student been diagnosed or treated for any of the following within the past two years?	Yes	No	Please explain
For any conditions marked "Yes" below, a separate note from a doctor is required.			
History of alcohol consumption or illicit drug use	☐	☐	
Eating disorder (Anorexia Nervosa, Bulimia Nervosa, other)? Diagnosed? Undiagnosed? Suspected	☐	☐	
Depression	☐	☐	
Bipolar Illness	☐	☐	
Schizophrenia	☐	☐	
Anxiety; Adjustment Disorder; Panic Attacks	☐	☐	
Attention or behavioural concerns/disturbance (including impulse control)	☐	☐	
Asperger's Syndrome Disorder	☐	☐	
History of suicidal behaviours, self-harm or thoughts, and/or psychosis	☐	☐	
Sought treatment/currently in mental health treatment or counselling	☐	☐	
Other: Please include any other relevant medical history	☐	☐	

Health history

Please tick all that apply.

Does the student have a history of:	Yes	No	Please explain
Migraine	☐	☐	
Concussion or head injury	☐	☐	
Epilepsy (grand or petit mal)	☐	☐	
Ear infection	☐	☐	
Sinus infection	☐	☐	
Mumps	☐	☐	
Strep throat	☐	☐	
Tuberculosis	☐	☐	
Asthma	☐	☐	
Heart disease	☐	☐	
Kidney or bladder disease	☐	☐	
Peptic ulcer	☐	☐	

Does the student currently have a history of:	Yes	No	Please explain
Menstrual problem	☐	☐	
Bowel disorder	☐	☐	
Arthritis or other joint disease	☐	☐	
Diabetes Mellitus	☐	☐	
Sexually transmitted disease	☐	☐	
Hepatitis A or B	☐	☐	
Malaria	☐	☐	
Infectious mononucleosis	☐	☐	
Rheumatic fever	☐	☐	

Please provide details if you marked "Yes" to any item in "Mental Health" and "Health history" above. You must provide us a separate note of the student's conditions.

_____

_____

Has the student had any other serious illness, any surgical operations, any constitutional disability? Please give particulars and dates.

_____

_____

Is there any reason to suspect the student may have problems adjusting to a boarding environment away from home?

_____

_____

Is there any other information you think the College should know? Please Elaborate.

_____

_____

Is the student a smoker? _____

Medications

☐ No

☐ Yes; provide a detailed list of current prescription and non-prescription medications.

Name of medication	Taken for symptom(s)/condition(s)	Dosage and frequency	Start date	Duration taking

Allergies (food/environment/medications)

☐ Not know allergy
☐ Yes; please provide details below:
Food: _____
Environment: _____
Medications: _____

Dietary requirements

If the student needs a vegetarian diet or a special diet for medical reasons, please state the requirements clearly.

_____

Family history

Has any member of the family had: Tuberculosis, mental disease, heart disease, diabetes, other serious illness or disease?

_____

_____

Because of the full and rigorous life at the College, we require that ANY physical, emotional or mental illness be brought to our attention, and the parent/guardian is asked to write to us confidentially on any such condition.

PART 3 MEDICAL CERTIFICATION

I certify that the information contained on the Medical Report are accurate and up to date to the best of my knowledge. My overall assessment of the above named individual is that he/she is:

☐ medically fit to join LPCUWC as boarding student and participate in all activities
☐ further discussion needed (please email me below)
☐ not medically able to join LPCUWC

Name of medical doctor/physician	Signature
Clinic Address (Clinic stamp/seal)	Date
Contact no. / email	

** Please send this Medical Report to the college together with:

☐ laboratory reports of blood test, urine test and chest x-ray (**report only, don't send film**).
☐ copy of immunization record/card only (**Don't** send original copy).

Please complete and return this form to the College by 30 June 2018.