Li Po Chun United World College of Hong Kong

MEDICAL REPORT

This form should be completed in **English only**.

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, please give details:

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.

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TO BE COMPLETED BY THE STUDENT'S DOCTOR ONLY. Please complete the form in English.

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 _____

_____

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 HISTORY

(A) **Required Immunizations**

ALL students <u>must present documentary evidence</u> 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: _____

You are encouraged to have Chicken Pox vaccination if you have not had Chicken Pox before.

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

HEALTH HISTORY (to be completed by **<u>Doctor only</u>**)

Has the student now or ever had the following illness, please indicate:

	YES	NO
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		
Menstrual problem		
Bowel disorder		
Arthritis or other joint disease		
Diabetes Mellitus		

	YES	NO
Sexually transmitted disease		
Hepatitis A or B		
Malaria		
Infectious mononucleosis		
Rheumatic fever		
Psychiatric Disorders		
Depression		
Panic disorder		
Anxiety		
Sleep disorder		
Eating disorder		

Allergies, please specify if yes:
Food: _____
Medication: _____
Others: _____

IF your answer is yes to any item in "Health History", please give details:

_____

_____

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

_____

_____

Is the student receiving any long-term medication now?

_____

_____

Does the student have any history of drug use?

_____

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

_____

_____

Has the student been receiving counselling for any reason? Give particulars and dates.

_____

_____

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

_____

_____

Is the student a smoker? _____

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

_____

_____

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.

Signature of Medical Doctor: _____

Name: _____

Address: _____

_____

Tel: _____

Fax: _____

Date: _____

** Please forward this Medical Report together with:

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