THE AMERICAN INTERNATIONAL SCHOOL OF MUSCAT

STUDENT PHYSICAL EXAMINATION AND HEALTH HISTORY

P.O. BOX 584
AZAIBA PC 130
SULTANATE OF OMAN

PHONE: +968-24 595-180
FAX: +968-24 503-815
EMAIL: taism@omantel.net.om

This page must be completed by a physician within six months prior to or no later than one month after admission to TAISM

Name: ____ Grade: _____

Male/Female __________ Birth date: _______________
(Day/Month/Year)

Height __________ Weight __________ Blood Pressure ________ Pulse _________ Blood Type (if known) __________

Allergies (food, medication, environment, etc.): ____

____

Vision: R ________ L ________ Hearing: ________________

	Normal	Abnormal	Explanation/Comments
Vision			
Hearing			
Nose, Throat			
Dental			
Respiratory Tract			
Digestive Tract			
Cardiovascular System			
Genito-urinary			
Neurological			
Musculoskeletal			
Skin			
Development for age			
Speech			

Please list any medical diagnosis for this child. ____

____

Overall appraisal of health, capabilities/limitations?____

____

Can the student participate in Physical Education/competitive sports? ___________________________________

Physician's Name: ___________________________ Signature: ________________________________

Telephone: _________________________________ Address: _________________________________

Date of Exam: ______________________________ Physician's Stamp:

(Day/Month/Year)

This page should be completed by parent/guardian

Immunization History (Enter date)

MANDATORY IMMUNIZATIONS	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Last Booster
HBV (Hepatitis B) - 3 Doses						
DPT (Diphtheria, Pertusis, Tetanus) - 5 Doses **Tdap** (Age 11-12)						
HIB (Haemophilus Influenza, Type B) - 3 Doses						
IPV (Polio Virus Vaccine) - 4 Doses						
MMR (Measles, Mumps, Rubella) - 2 Doses						
BCG (Tuberculosis) and/ **TBC** (Tubercular Skin Test)	Positive __	Negative __				
RECOMMENDED IMMUNIZATIONS	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**	**Last Booster**
PCV (Pneumococcal Conjugate Vaccine) – 4 Doses						
Chicken Pox (Varicella) – 2 Doses						
Hepatitis A – 2 Doses						
MCV4 (Meningitis) (Age 11-12)						
HPV (Human Papillomavirus) – 3 Doses						

Student Health History

	Yes	No		Yes	No
Abdominal Complaints	________	________	Menstrual Problems	________	________
Allergies	________	________	Skin & Hair	________	________
Asthma	________	________	Surgery/Fractures	________	________
Chicken Pox	________	________	Tonsillitis	________	________
History of Ear Infections	________	________	Tuberculosis	________	________
Head Injuries	________	________	Whooping Cough	________	________
History of High Fevers	________	________			

If "yes" to any of the above, please provide details: ____

____

Please list any other health conditions the school needs to be aware of, to meet the needs of the child: ______________

____

Date: ______________________ (Day/ Month/ Year)

Signature: ____ (Parent or Guardian)

Printed Name: ____