THE AMERICAN INTERNATIONAL SCHOOL OF MUSCAT

STUDENT PHYSICAL EXAMINATION AND HEALTH HISTORY

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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 (MM/DD/YYYY)

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						
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						
BCG (Tuberculosis)						
TBC (Tubercular Skin Test)		Negative___	Positive __			

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: _____ (Month/ Day/ Year)

Signature: _____ (Parent or Guardian)

Printed Name: _____