LEADERS INTERNATIONAL
CHRISTIAN SCHOOL OF MANILA

MEDICAL EXAMINATION FORM

(To be completed by the child's pediatrician handling the applicant not lesser than 2 years)

STUDENT'S NAME: ____ NICKNAME: ________________________

SEX: __M __F BIRTHDATE: (MM/DD/YY) ____________ GRADE (in which enrolling): __________

MEDICAL EXAMINATION

General Appearance ______________________ Ears ________________ Pulse ______________

General Nutrition ________________________ Nose & Throat ____________________________________

Abdomen ______________________________ Posture (Scoliosis) Yes___ No ___

Mouth ________________________________ Bones & Muscle ____________________________________

Teeth & Gums ___________________________ Nervous System ____________________________________

Height ________________________________ Weight ____

Glands ________________________________ Emotional Problems _________________________________

Skin __________________________________ Breasts ____

Vision _________________________________ Scalp ____

Heart murmurs __________________________ Blood pressure ____________________________________

ALLERGIES & REACTION: ____

CHRONIC MEDICAL CONDITIONS: (e.g. Asthma, Diabetes, Skin Allergies, etc): ______________________

ANY LABORATORY TESTS DONE AND RESULTS: ____

RECOMMENDATIONS:

1. Is special sitting recommended? Yes ____ No ____
2. Does child have any uncorrectable defects? Yes ____ No ____
3. Does he/she require any regular medication? Yes ____ No ____
4. Does child require continuing medical treatment? Yes ____ No ____
5. Is there evidence of emotional upset? Yes ____ No ____
6. Is there need for dietary corrections? Yes ____ No ____
7. Does child require vision correction? Yes ____ No ____
8. **Has child been diagnosed/assessed to have Learning Disabilities including but not limited to ADHD, Autism, Speech Delay, etc./Physical Disabilities? Yes ____ No ____**

No. 1-8 if yes, please provide details:

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Is pupil capable of carrying a full academic workload? Yes ____ No ____

PHYSICAL ACTIVITY & SPORTS RECOMMENDATIONS:

Is pupil capable of unlimited physical activity? Yes ____ No ____

If NO, please give specific guidelines or restrictions: _______________________________________

PHYSICIAN'S NAME ____

LICENSE NUMBER: ____________________________ Name of hospital or clinic: ___________________________

PHYSICIAN'S SIGNATURE: ______________________ Contact no: ____

Date of examination: ______________________________

PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATIONS RECORD ALONG WITH THIS FORM