

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: \_\_\_\_\_

Tel. For Emergency Contact: \_\_\_\_\_

Given Names: \_\_\_\_\_

Do you already have health insurance? Yes/No

Sex: Male/Female

If Yes, please give details: Insurance

Date of Birth (dd/mm/yy): \_\_\_\_\_

Company Name: \_\_\_\_\_

Parent or Guardian's Name: \_\_\_\_\_

Policy Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Does this include:

Dental Yes No

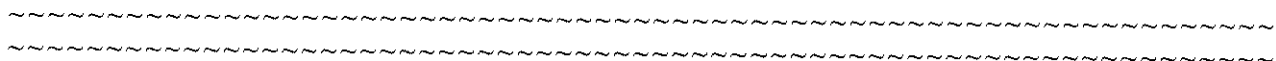
Prescription medications Yes No

Counsellor or psychologist Yes No

E-mail address: \_\_\_\_\_

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

Home Telephone: \_\_\_\_\_



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

Height \_\_\_\_\_ cm

1. Chest X-Ray: must be taken within recent six months: Date: \_\_\_\_\_

Weight \_\_\_\_\_ kg

X-Ray report: \_\_\_\_\_

Blood Pressure \_\_\_\_\_ mmHg

Pulse \_\_\_\_\_ /min

2. Urine (full & microscopic examinations):

Ear Nose Throat \_\_\_\_\_

\_\_\_\_\_

Abdomen \_\_\_\_\_

3. Blood test:

Locomotor System \_\_\_\_\_

Haemoglobin \_\_\_\_\_ Date: \_\_\_\_\_

Central Nervous System \_\_\_\_\_

HBsAg \_\_\_\_\_ Date: \_\_\_\_\_

Respiratory System \_\_\_\_\_

HBsAb \_\_\_\_\_ Date: \_\_\_\_\_

Cardiovascular System \_\_\_\_\_

4. Remarks: \_\_\_\_\_

Investigation of other conditions \_\_\_\_\_

\_\_\_\_\_

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.

New students are encouraged to undergo blood tests before they leave home to determine whether or not they are seropositive. If adequate test arrangements are not available at home, arrangements can be made by the College at the student's cost after arrival here.

We require that the students be immunized adequately and be up to date with booster inoculations. This refers to Tetanus, Rubella and Hepatitis B. Boosters must have been given against Tetanus between the ages of thirteen and sixteen.

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	Date of Booster
Tetanus		
Hepatitis B		
Rubella		N.A.

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
Typhoid	
Menigococcus	

Have you had Children Pox before:

- Yes, date: \_\_\_\_\_  No

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

- 1<sup>st</sup> dose. Date: \_\_\_\_\_  2<sup>nd</sup> dose. Date: \_\_\_\_\_

**HEALTH HISTORY** (to be completed by **Doctor only**)

Please answer the following questions. Check Yes or No in the columns indicated. Has the student now or ever had:

	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		

	YES	NO
Diabetes Mellitus		
Sexually transmitted disease		
Hepatitis A or B		
Malaria		
Infectious mononucleosis		
Rheumatic fever		
Allergies, please specify if yes: Food: _____ Medication: _____ Others: _____		
Psychiatric problems		
Mood disorder		
Anxiety		
Panic attacks		
Sleep disorders		
Eating disorders		

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

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

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**FAMILY HISTORY**

Has any member of the family had:

Tuberculosis, mental disease, heart disease, diabetes, other serious illness or disease?

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

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If the student needs a special diet for medical reasons, please state the requirements clearly. If a vegetarian diet is requested, please include foods eaten.

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

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Is the student a smoker? \_\_\_\_\_

Is the student receiving any long-term medication?

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Does the student have any history of drug use?

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Is there any other information you think the College should be given?

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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 Examiner: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

Date: \_\_\_\_\_