

MEDICAL REPORT

To be completed and signed by a medical physician. This form should be completed in English only.

To the Physician: This individual has been nominated as a scholar to study the two-year International Baccalaureate Diploma Programme at Li Po Chun United World College of Hong Kong. The UWC experience can ask a lot from the student both physically and mentally. Thus, it is necessary for us to seek a professional evaluation of the student's physical and mental health.

The report will be kept **confidential** and is shared only with the school nurse, the appointed medical physician, and if required, with appropriate staff members.

PART 1 PERSONAL INFORMATION (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: _____

Country of Residence: _____ E-mail address: _____

Home Telephone: _____ Tel. For Emergency Contact: _____

Do you have health insurance in Hong Kong? Yes/No

If Yes, does it include:

Hospitalization	Yes	No
Outpatient service	Yes	No
Dental	Yes	No
Prescription medications	Yes	No
Counsellor or psychologist	Yes	No

PART 2 MEDICAL CONDITIONS (To be completed and signed by a medical physician)

Physical health

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 _____

Laboratory reports

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. It is important for us to know whether a student is a carrier or not to give suitable advice to students.

Immunization Records

(A) Required Immunizations

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 (dd/mm/yy)
Tetanus	
Booster for Tetanus (should be within the recent 8 years)	
Hepatitis B	
MMR	

(B) Recommended Immunizations

Students may 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: _____

If No, you are encouraged to have Chicken Pox vaccination.

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

Health history

Have you been tested positive for COVID-19 before: No Yes, date: _____

Have you received COVID-19 vaccination: No Yes, brand: _____

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

Please tick all that apply.

Does the student have a history of:	Yes	No	Please explain
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	
Concussion or head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy (grand or petit mal)	<input type="checkbox"/>	<input type="checkbox"/>	
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Strep throat	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney or bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
Menstrual problem	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis or other joint disease	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A or B	<input type="checkbox"/>	<input type="checkbox"/>	
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	
Infectious mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	

Mental health

Please tick all that apply.

Has the student been diagnosed or treated for any of the following?	Yes	No	Please explain
For any conditions marked "Yes" below, a separate note from a doctor is required.			
History of alcohol consumption or illicit drug use	<input type="checkbox"/>	<input type="checkbox"/>	
Eating disorder (Anorexia Nervosa, Bulimia Nervosa, other)? Diagnosed? Undiagnosed? Suspected?	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety; Adjustment Disorder; Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Attention or behavioural concerns/disturbance (including impulse control)	<input type="checkbox"/>	<input type="checkbox"/>	
Asperger's Syndrome Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
History of suicidal behaviours or thoughts	<input type="checkbox"/>	<input type="checkbox"/>	
History of self-harm behaviours or thoughts	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	
Sought treatment/currently in mental health treatment or counselling	<input type="checkbox"/>	<input type="checkbox"/>	
Other: Please include any other relevant medical history	<input type="checkbox"/>	<input type="checkbox"/>	

Please provide details if you marked "Yes" to any item in "Health history" and "Mental health" above. You must provide us a separate note of the student's conditions.

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

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

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

Is the student a smoker? _____

Medications

- No
- Yes; provide a detailed list of current prescription and non-prescription medications.

Name of medication	Taken for symptom(s)/condition(s)	Dosage and frequency	Start date	Duration taking

Allergies (food/environment/medication)

- No known allergy
- Yes; please provide details below:

Food: _____
Environment: _____
Medications: _____

Dietary requirements

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

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.

PART 3 MEDICAL CERTIFICATION

I certify that the information contained on the Medical Report are accurate and up to date to the best of my knowledge. My overall assessment of the above-named individual is that he/she is:

- medically fit to join LPCUWC as boarding student and participate in all activities
- further discussion needed (please email me below)
- not medically able to join LPCUWC

Name of medical doctor/physician	Signature
Clinic Address (Clinic stamp/seal)	Date
Contact no. / email	

**** End of Medical Report****

To student: please send this Medical Report to the college together with:

- laboratory reports of blood test
- laboratory reports of urine test
- laboratory reports of chest X-Ray (**report only, don't send film**)
- copy of immunization record/card (**don't** send original copy)

Please complete and return this form to the College by 30 June 2021.