39 Yeonhui-ro 22-gil, Seodaemun-gu
Seoul, Korea 03723
Tel: (82-2) 330-3203
Fax: (82-2) 333-5027
E-mail: sfsnurseoffice@seoulforeign.org

Please return this form to Health Office PRIOR TO the student's start date at SFS.

Part II – Report of Medical Examination

*This page needs to be filled out by a **PHYSICIAN**.

Student's Name: Last_____, First_____Middle_____

Date of Birth (mm/dd/yr): _____/_____/_____ Grade/Year _____

Height_____cm Weight_____kg Blood Pressure_____/_____(ONLY for students age 11 and older) Pulse_____

Vision: R _____ L _____ Both _____ Corrective Lens: ☐ Yes / ☐ No

NOTE: Please administer the following REQUIRED tests.	Date (mm/dd/yr)	Result
Tuberculosis Skin Test OR Chest X-ray OR TB blood test (IGRA) (NOTE: If TB skin test result is positive, either chest X-ray or TB blood test (IGRA) is required regardless of previous BCG vaccination.)		TB skin test: Chest X-ray: TB blood test (IGRA):
Hemoglobin (Students under 5 years of age are exempt from this test.)		
Urinalysis (Students under 3 years of age are exempt from this test.)		

	Normal	Abnormal		Normal	Abnormal
Ears/Hearing			Musculoskeletal		
Nose			Spine		
Mouth			Skin		
Throat			Neurological		
Neck			Nutritional		
Heart			Emotional/Psychological		
Lungs			Behavior		
Abdomen			Speech		

Physician's Comments:

Please list any medication the student takes on a regular basis.
NOTE: A separate medical form (Part III) is required for all medication and treatment to be administered at school.

Name of Medication	Purpose	Dose/Time

» **This student is physically able to participate in all physical education and sports activities: ☐ Yes / ☐ No**

If NO, please explain:

_____

NOTE TO THE PHYSICIAN: SFS follows the U.S. CDC immunization schedule. Please help us ensure this student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio & MMR at age 4-6 and DT/Td/Tdap at age 11-12. Immunization record is on a separate form (Part I - 3). If immunization is administered, please complete the form. Thank you.

** Please note that SFS does NOT accept a student's physical exam certified by a parent who may be a physician or medical professional.*

Physician Signature	**Date of Examination (mm/dd/yr)**
Printed Name	**Clinic Name & Phone Number**