



# Medical Examination Form 体检表

## To be completed by a medical physician 医生填写:

Student's Family Name 学生的姓: \_\_\_\_\_  
 First Name 学生的名: \_\_\_\_\_ Middle Name 中间名字: \_\_\_\_\_  
 Student's Birth Date 生日: Month 月 \_\_\_\_\_ Day 日 \_\_\_\_\_ Year 年 \_\_\_\_\_  
 Grade in August 年级 \_\_\_\_\_  
 Height (cm) 身高 (厘米): \_\_\_\_\_ Weight (kg) 体重 (公斤) \_\_\_\_\_  
 Pulse 脉搏: \_\_\_\_\_ B/P 血压: \_\_\_\_\_/\_\_\_\_\_

## Physical Exam 体检:

	Normal 正常	Abnormal 不正常	Physician's Comments, Findings, Tests, ETC. 医生意见, 结论, 测试等
General Appearance 一般情况			
Neurologic 神经系统			
Musculoskeletal (including Scoliosis check) 肌肉骨骼系统 (包括脊柱侧凸检查)			
Skin, Scalp 皮肤, 头皮			
Eyes 眼睛			
Vision Screening 视力			
Ears 耳朵			
Hearing Screening 听力			
Speech 语言			
Nose 鼻子			
Throat 咽喉			
Mouth, Teeth 口, 牙齿			
Glands, Thyroid 腺体, 甲状腺			
Heart 心脏			
Lungs 肺部			
Abdomen 腹部			
Genitourinary 泌尿生殖器			
Mental Health and Cognition 心理健康和认知			
Emotional Health + Behavioral Health 情感健康 + 行为健康			

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Has the child undergone any surgical procedure? 孩子接受过任何手术?

Yes 是     No 否

If yes, please specify when and the nature of surgery 如果是, 请详细说明手术时间和手术类型:

### Physical Activities 体育活动 (Normal physical education classes, swimming and competitive sports)

(一般的体育课程, 游泳和体育比赛)

Unrestricted 没有限制 \_\_\_\_\_ Modified 不能参加的体育活动 \_\_\_\_\_

If modified, please explain 请解释不能参加的原因: \_\_\_\_\_

### Medication 药物治疗

Is this student taking any medication (oral or injected) on a regular basis ? 学生是否定期服药 (口服或针剂)?

Yes 是     No 否

If "yes" please explain 如果是, 请详细说明: \_\_\_\_\_

### This student has completed the minimal immunization requirements for attendance at WYIS

该学生已经完成在 WYIS 上学所需的免疫接种:  Yes 是     No 否

Please check 请打勾

Required Immunizations 所需免疫接种

Yes 是	No 否	
		DTP(Diphtheria, Tetanus, Pertussis) (白喉, 破伤风, 百日咳)
		POLIO 脊髓灰质炎
		MMR(Measles, Mumps, Rubella) (麻疹, 腮腺炎, 风疹)
		Hepatitis B (乙肝)
		BCG <u>or</u> 卡介苗 <u>或者</u>
		PPD or MANTOUX SKIN TEST and/or CHEST X-RAY in Last 24 months.过去的 24 个月中接受过结核菌皮肤实验或曼托皮肤测试和/或胸部 X 光检查
Result of last skin test and/or chest x-ray 最近的皮肤测试和/或胸部 X 光片的结果		

### In my opinion this student is free of any communicable disease.

此学生无任何传染病。  Yes 是     No 否

Additional Comments 附加信息: \_\_\_\_\_

Doctor's Name 医生姓名 (Block Letters 大写): \_\_\_\_\_

Signature 签名: \_\_\_\_\_ Date of Examination 体检日期: \_\_\_\_\_

Address 地址: \_\_\_\_\_

Telephone 电话: \_\_\_\_\_ Fax 传真: \_\_\_\_\_

Email Address 电邮地址: \_\_\_\_\_

