CLINIC
STUDENT CLINIC CARD

(School Year 2021–2022)

RUAMRUDEE INTERNATIONAL SCHOOL
6 RAMKAMHAENG 184, MINBURI
BANGKOK 10510, THAILAND
TEL: 02-791-8900 • FAX: 02-791-8901 to 2
www.rism.ac.th • info@rism.ac.th

RIS • SWISS • SECTION
DEUTSCHSPRACHIGE SCHULE BANGKOK

FIRST NAME _____ LAST NAME _____ NICK NAME _____ GENDER _____ DATE OF BIRTH _____ AGE _____

GRADE _____ NATIONALITY(IES) _____ / _____ HEIGHT (*cms*) _____ WEIGHT (*kg*) _____

HOME ADDRESS _____ NAME OF SIBLING IN RIS _____ GRADE _____ ☐ BROTHER ☐ SISTER

HOME ADDRESS (*continued*) _____ NAME OF SIBLING IN RIS _____ GRADE _____ ☐ BROTHER ☐ SISTER

FATHER'S NAME _____ MOTHER'S NAME _____

NAME OF EMPLOYER _____ NAME OF EMPLOYER _____

OFFICE ADDRESS _____ OFFICE ADDRESS _____

OFFICE ADDRESS (*continued*) _____ OFFICE ADDRESS (*continued*) _____

OFFICE NUMBER _____ MOBILE NUMBER(S) _____ OFFICE NUMBER _____ MOBILE NUMBER(S) _____

IN CASE OF EMERGENCY CONTACT

NAME _____ CONTACT NUMBER _____

Has your child received any vaccines this year?

TYPE _____ DATE _____ TYPE _____ DATE _____

Medical History

☐ YES ☐ NO

DIAGNOSIS OR OPERATION _____ DATE _____

CURRENT MEDICATION _____

ALLERGIES TO FOOD & MEDICATION _____

MEDICATION USED TO TREAT ALLERGIES _____

Permission for School Clinic staff to administer medication

☐ ALLOWED TO BE ADMINISTERED FIRST-AID TREATMENT INCLUDING NON-PRESCRIPTION MEDICINE FOR FIRST-AID.

☐ NOT ALLOWED TO TAKE ANY MEDICATION EXCEPT EXTERNAL TREATMENT FOR FIRST AID.

I give permission for Ruamrudee International School authorities to sign on my behalf should my children need emergency treatment at the hospital and I cannot be reached in time. This permission does not, however, include the administering of blood transfusions.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

CLINIC
STUDENT HEALTH DATA

RUAMRUDEE INTERNATIONAL SCHOOL
6 RAMKAMHAENG 184, MINBURI
BANGKOK 10510, THAILAND
TEL: 02-791-8900 • FAX: 02-791-8901 to 2
www.rism.ac.th • info@rism.ac.th

MEDICAL EXAMINATION RECORD

RIS • SWISS • SECTION
DEUTSCHSPRACHIGE SCHULE BANGKOK

(School Year 2021–2022)

FIRST NAME _____ LAST NAME _____ NICK NAME _____

GRADE _____ DATE OF BIRTH _____ AGE _____ GENDER _____ NATIONALITY _____

DATE _____

IMMUNIZATION / VACCINE	DATE(S) ADMINISTERED	COMPLETED	ADDITIONAL REMARKS
BCG (Tuberculosis)		☐ YES ☐ NO	
DPT (Diphtheria, Whooping Cough, Tetanus)		☐ YES ☐ NO	
POLIOMYELITIS		☐ YES ☐ NO	
MUMPS		☐ YES ☐ NO	
MEASLES & RUBELLA		☐ YES ☐ NO	
HEPATITIS A		☐ YES ☐ NO	
HEPATITIS B		☐ YES ☐ NO	
JAPANESE B ENCEPHALITIS		☐ YES ☐ NO	
TYPHOID		☐ YES ☐ NO	
OTHER		☐ YES ☐ NO	

PHYSICAL EXAMINATION
BY PHYSICIAN

MEDICAL HISTORY:

RECOMMENDATION & SUMMARY OF DEFECTS:

NOSE _____ THROAT _____ HEART _____

ABDOMEN _____ GLAND _____

BLOOD PRESSURE _____ MM/HG

LUNGS (X-RAYS/TINE TEST) _____

HEIGHT _____ CM WEIGHT _____ KG

NUTRITIONAL STATUS _____ BLOOD GROUP _____ RH

ALLERGIC HISTORY _____ MEDICATION _____

NAME & SIGNATURE AND/OR STAMP:

COMPLETE BLOOD COUNT (FOR STUDENT OVER 12 YEARS)

HB _____ /HPF HCT _____ % WBC _____

PLATELET _____ L _____ % M _____ % E _____ % B _____ %

NAME & SIGNATURE AND/OR STAMP:

EYE CHECK
BY AN EYE SPECIALIST

VISION: RIGHT EYE _____

LEFT EYE: _____

COLOR BLINDNESS: _____

GLASSES
☐ WEARS ☐ NEEDS

CONTACT LENS
☐ WEARS ☐ NEEDS

REMARKS:

NAME & SIGNATURE AND/OR STAMP:

DENTAL CHECK
BY A DENTIST

FINDINGS:

RECOMMENDATION:

NAME & SIGNATURE AND/OR STAMP:

AUDIOMETRIC HEARING TEST
BY AN ENT SPECIALIST

RIGHT EAR _____

LEFT EAR _____

FINDINGS:

RECOMMENDATION:

NAME & SIGNATURE AND/OR STAMP:

URINALYSIS

SP. GR. _____ PH _____

ALBUMIN _____ RBC _____/HPF WBC _____/HPF

NAME & SIGNATURE AND/OR STAMP:

SUMMARY OF DIAGNOSIS & RECOMMENDATION

NAME & SIGNATURE AND/OR STAMP:

I certify that all the aforementioned information given is complete and correct.

STAMP:

_____ _____

PHYSICIAN'S NAME SIGNATURE