Thetford
ACADEMY

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INTERNATIONAL STUDENT PHYSICAL EXAMINATION REPORT

PART 1 (*To be completed ANNUALLY by student / parents*)

Student's First Name | Student Middle Name / Initial | Family Name

Date of Birth (Month / Day / Year)

Address | City / State | Postal Code | Country

Have you had or do you have:

❑ Allergies (explain:)

_____

_____

_____

❑ Anxiety

❑ Asthma

❑ Chronic Diseases: (explain:)

_____

_____

_____

❑ Depression

❑ Diabetes

❑ Dietary Restrictions (explain:)

_____

❑ Emotional/Behavioral challenges (explain:)

_____

_____

_____

❑ Epilepsy

❑ Frequent Earaches

❑ Physical challenges, injuries, orthopedic

❑ Heart Disease

❑ Pre-Existing Injury (explain:)

_____

_____

_____

❑ Rheumatic Fever

_____ ❑ Other (explain:)

_____ _____

_____ _____

_____

_____ _____

Student Name *Date of Birth*

Have you had or do you have:

Loss of eye, lung, kidney, ovary or testes? ❑ Yes ❑ No (If yes, explain:) _____

_____

Loss of consciousness with head injury? ❑ Yes ❑ No (explain:) _____

Date:_____ Activity Restrictions: _____

Any serious illness in the last year? ❑ Yes ❑ No (If yes, explain:)

_____

_____

Started menstruating? ❑ Yes ❑ No

Any special Dental or Orthodontic needs: ❑ Yes ❑ No

Had a dental exam within the last 6 months? ❑ Yes ❑ No
(Thetford Academy recommends getting a dental checkup each year before arriving at school)

Had loss of vision or hearing within the past 3 months? ❑ Yes ❑ No (If yes, explain:)

_____

Do you:

Wear a hearing aid? ❑ Yes ❑ No

Wear glasses? ❑ Yes ❑ No

Wear contact lenses? ❑ Yes ❑ No

Have you had Covid-19? ❑ Yes ❑ No if YES, date of positive TEST: _____

Dates of Covid VACCINATIONS:_____

_____

Signature of **Student** Date

_____

Signature of **Parent** Date