



# International School of Islamabad HEALTH FORM

Employee Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_

Permanent Address: \_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Person: Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**To be completed by the physician:**

**Attach a copy of the following lab reports:** 1) Complete Blood Count including Cholesterol Levels, 2) Routine Urine Analysis, and 3) Chest X-ray report.

**Physical Exam:**

Vitals: B/P \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Respiratory Rate \_\_\_\_\_ Weight \_\_\_\_\_

Height \_\_\_\_\_ LMP \_\_\_\_\_

Allergies: \_\_\_\_\_

History of TB or other Medical Conditions: \_\_\_\_\_

	Within Normal Limits	Observations/Comments
Head and ENT (Ears Nose & Throat)		
Eyes		
Neck and nodes		
Cardiovascular		
Respiratory		
Abdomen		
Musculoskeletal		
Skin		
Recent Mammogram (if over the age of 40)		
Recent Pap Smear		
Male PSA Screening (if over the age of 40)		

Assessment: \_\_\_\_\_

Plan: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

# HEALTH FORM

## NECESSARY VACCINATIONS:

	Date Dose / Booster Dose
Td ( Tetanus & Diphtheria)	
POLIO (OPV)	
MMR (Measles, Mumps & Rubella)	
PPD (Tuberculosis test)	
HEPATITIS A	
HEPATITIS B	
RABIES (Optional)	
YELLOW FEVER (if coming from Africa)	
TYPHOID (Oral / Injected)	

I hereby allow my Physical Examination Reports to be released by the above physician to Ms. Rose Puffer at the International School of Islamabad PO Box 1124, Sector H9/1, Islamabad, Pakistan - 44000.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date