KOREA CHRISTIAN INTERNATIONAL SCHOOL

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CERTIFICATE OF HEALTH

Name		***Resident Registration Number***		
School Name				*(Photo)*
Height	cm	***Weight***	kg	
Distant Vision	***Uncorrected***	*Left:*	*Right:*	
	Corrected	*Left:*	*Right:*	
Color Vision		***Eye Disease***		
Hearing	***Left:***	***Right:***		
Blood Pressure	/ mmHg	***Lungs & Heart***		
Abdomen		***Infectious Disease***		
Neurologic	☐ Normal ☐Abnormal	***Psychiatric***	☐ Normal ☐Abnormal	
X-ray Examination	***Date:***	***Film No.***	***Result:***	
Urinalysis	☐ Normal ☐Abnormal	***Stool Test***	☐ Normal ☐Abnormal	
Hemoglobin	g/dℓ	***ESR***	mm/hr	
AIDS	☐ Positive ☐ Negative	***VDRL***	☐ Positive ☐ Negative	
Hepatitis Test	***HBsAg***	☐ Positive ☐ Negative	***HBsAb***	☐ Positive ☐ Negative
Tuberculin	☐ Positive ☐ Negative	***Others***		

The Date of Issue (MM/DD/YY): _____

Hospital Name: _____

License No. _____

Doctor's Name: _____ ***Signature:*** _____

DENTAL CHECK LIST

Dental Examination Result			
Teeth Decay	☐ No	☐ Yes: Upper ( ), Lower ( )	
Dental Caries Risk	☐ No	☐ Yes: Upper ( ), Lower ( )	
Missing Teeth	☐ No	☐ Yes: Upper ( ), Lower ( )	
Periodontal Disease	☐ No	☐ Yes: Gingival enlargement, tartar, periodontal pocket others ( )	
Teeth Grinding	☐ No	☐ Yes	
Third Molars	☐ Normal	☐ Abnormal ( )	
Canker Sore & Soft Tissue Defect	☐ No	☐ Yes	
Jaw Abnormalities	☐ No	☐ Yes	
Denture	☐ Unnecessary	☐ Necessary (Upper / Lower)	☐ Existing (Upper / Lower)
Other	A N U G, Lingua geographical supernumerary teeth, remaining primary teeth, congenitally missing teeth, misaligned teeth, Others ( )		

Comprehensive Opinion	
1	No treatment required
2	Dental caries (teeth decay) treatment required
3	Replacing teeth with new ones needed
4	Tartar and plaque removal (scaling) needed
5	Surgery on gums needed
6	Pulling out teeth needed. (wisdom teeth, teeth with only roots, shaking teeth)
7	Treatment of soft tissue defect required
8	Jaw abnormalities treatment required
9	Dentures treatment required
10	Urgent dental treatment required
11	Re-examining or treating teeth which were treated needed
12	Others ( )

Examining Facility	***Name***		***Date Examined***		***Date Issued***	
	No.		***Medical Examiner's License or Certificate No.***		***Signature of Examining Dentist***	