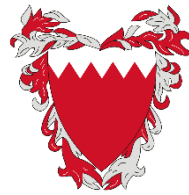


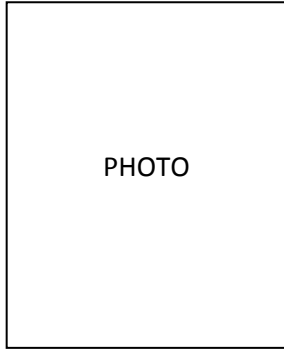


THE ASIAN SCHOOL  
KINGDOM OF BAHRAIN



KINGDOM OF BAHRAIN  
MINISTRY OF HEALTH

**HEALTH CENTER / PRIVATE CLINIC**  
**HEALTH REPORT TO THE SCHOOL**



Health Center/Private Clinic: \_\_\_\_\_

Student's full name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Age at examination: \_\_\_\_\_ years \_\_\_\_\_ months

Health Record no: \_\_\_\_\_ Family File no: \_\_\_\_\_

C.P.R. no: \_\_\_\_\_ Mob. no: \_\_\_\_\_

After reviewing the vaccination card and the health record of the above mentioned student, whose photo is attached, and examining him/her by the physician concerned and the dentist, the following is/are advised:

- Fit to join the school
- Needs assessment of his/her learning capabilities

Please specify reasons: \_\_\_\_\_

Needs further assessment and/or treatment by: \_\_\_\_\_

Needs dental follow up, next appointment on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Needs completion of immunization, due on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Needs special care at school, because of: \_\_\_\_\_

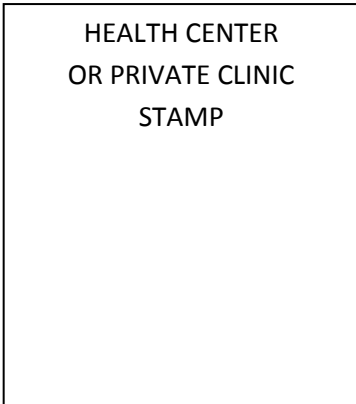
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Physician's Name & Signature

\_\_\_\_\_  
\_\_\_\_\_

Dentist's Name & Signature:

\_\_\_\_\_  
\_\_\_\_\_



<b>Recommended Immunization Schedule in the Kingdom of Bahrain</b>			
<b>AGE</b>	<b>VACCINE</b>	<b>DOSE</b>	<b>Date of Vaccine</b>
<b>CHILDREN</b>			
At birth	BCG for newborns born to parents originally from endemic countries	Single Dose	___ / ___ / ____
	Hepatitis B for all newborns	Birth Dose	___ / ___ / ____
2 months	DaPT (Diphtheria, Pertussis, Tetanus) Hepatitis B, Haemophilus influenza Type B (Hib), + Inactivated Polio (as Hexavalent)	1 <sup>st</sup> Dose	___ / ___ / ____
	Pneumococcal Conjugate (PCV)	1 <sup>st</sup> Dose	___ / ___ / ____
	Rota Vaccine (oral)	1 <sup>st</sup> Dose	___ / ___ / ____
4 months	DaPT + Hepatitis B, Haemophilus Influenza Type B (Hib), + Inactivated Polio (as Hexavalent)	2 <sup>nd</sup> Dose	___ / ___ / ____
	Oral Polio Vaccine (OPV)	2 <sup>nd</sup> Dose	___ / ___ / ____
	Pneumococcal Conjugate (PCV)	2 <sup>nd</sup> Dose	___ / ___ / ____
	Rota Vaccine (Oral)	2 <sup>nd</sup> Dose	___ / ___ / ____
6 months	DPT + Hepatitis B + Hib (Pentavalent)	3 <sup>rd</sup> Dose	___ / ___ / ____
	Oral Polio Vaccine (OPV)	3 <sup>rd</sup> Dose	___ / ___ / ____
	Pneumococcal Conjugate (PCV)	3 <sup>rd</sup> Dose	___ / ___ / ____
12 months	MMR (Measles, Mumps, Rubella)	1 <sup>st</sup> Dose	___ / ___ / ____
	Varicella	1 <sup>st</sup> Dose	___ / ___ / ____
15 months	Pneumococcal Conjugate (PCV)	Booster	___ / ___ / ____
	Hepatitis A	1 <sup>st</sup> Dose	___ / ___ / ____
18 months	MMR (Measles, Mumps, Rubella)	2 <sup>nd</sup> Dose	___ / ___ / ____
	DPT + Hib (Tetavalent) or Pentavalant (according to availability)	Booster	___ / ___ / ____
	Polio Vaccine Oral (OPV)	1 <sup>st</sup> Booster	___ / ___ / ____
2 years	Meningococcal Conjugate (ACYW)	Single Dose	___ / ___ / ____
	Hepatitis A	2 <sup>nd</sup> Dose	___ / ___ / ____
3 Years	Varicella	2 <sup>nd</sup> Dose	___ / ___ / ____
4-5 years	DTaP-IPV (Diphtheria, Tetanus, Pertussis, Inactivated Polio)	2 <sup>nd</sup> Booster	___ / ___ / ____
	Oral Polio Vaccine (OPV)	2 <sup>nd</sup> Booster	___ / ___ / ____
	MMR (Measles, Mumps, Rubella) if no document of 2 valid doses MMR vaccination previously	2 <sup>nd</sup> Dose	___ / ___ / ____
<b>ADOLESCENTS</b>			
12 years	Hepatitis A as catch up for Hep A unvaccinated	1 <sup>st</sup> Dose	___ / ___ / ____
13 years	Tdap (Tetanus, Diphtheria, Pertussis)	Booster	___ / ___ / ____
	Hepatitis A as catch up for Hep A unvaccinated	2 <sup>nd</sup> Dose	___ / ___ / ____