ACST MEDICAL EXAMINATION FORM

اِستمارة الفحص الطبي

- This form is to be completed in full and signed by a parent and physician ***before*** a student attends classes or participates in any activity.
- This form may be completed in your home country but may not be dated any earlier than six months prior to the start of the school term.
- **ACST reserves the right to withhold a student from classes and activities until this form is completed in full and returned to the Nurse's office.**
- Parents, please make a copy of the completed form for your records.

attach student photo

PERSONAL AND CONTACT INFORMATION / المعلومات الشخصية و الاتصال

STUDENT NAME		
DATE OF BIRTH	GRADE	SEX: M F
NAME OF MOTHER/GUARDIAN 1	**NAME OF FATHER/GUARDIAN 2**	

ADDRESS IN TUNISIA

	HOME TELEPHONE	WORK TELEPHONE	MOBILE TELEPHONE
MOTHER/GUARDIAN 1			
FATHER/GUARDIAN 2			

NAME OF PHYSICIAN IN TUNISIA

PHYSICIAN PHONE NUMBER

EMERGENCY CONTACT NAME

RELATIONSHIP **PHONE**

MEDICAL HISTORY to be filled out by a physician / معلومات طبية بعد فحص طبي

HEALTH HISTORY	YES	NO
CHRONIC ILLNESS		
HOSPITALIZATION		
SURGERY		
MIGRAINES/HEADACHES		
DIZZINESS/FAINTING		
SEIZURES/CONVULSION		
CONCUSSION		
RESPIRATORY/ASTHMA		
HEART		
KIDNEY/BLADDER		
GI/ABDOMEN		
SKIN		
ORTHOPEDIC/JOINTS		

ALLERGIES:

TREATMENT:

HEIGHT (cm)	WEIGHT (kg)	
	YES	NO
GLASSES		
HEARING AID		
DENTAL/BRACES		
SPINE		

BEHAVIORAL/EMOTIONAL CONCERNS:

DAILY OR EMERGENCY MEDICATIONS:

SUMMARY OF ANY YES ANSWERS OR ABNORMAL FINDINGS:

PHYSICAL EDUCATION PARTICIPATION APPROVED	YES	NO
COMPETITIVE SPORTS PARTICIPATION APPROVED	YES	NO

LIMITATIONS:

PHYSICIAN SIGNATURE, DATE AND STAMP / إمضاءالطبيب

VACCINATIONS (photo copy of immunization card preferred) / التطعيمات

THE IMMUNIZATIONS LISTED BELOW ARE MANDATORY FOR ADMISSION TO ACST							REMARKS
DPT*							
TETANUS							
POLIO							
MEASLES*							
MUMPS*							
RUBELLA*							
HEPATITIS B							
Optional:							
CHICKEN POX							
BCG							

**DPT: DIPTHERIA, PERTUSSIS, AND TETANUS ALSO KNOWN AS DTaP OR TDaP*

**MEASLES, MUMPS, AND RUBELLA MAY BE GIVEN AS THE COMBINED VACCINE MMR*

IF YOUR CHILD'S IMMUNIZATION RECORDS HAVE BEEN LOST, WE REQUIRE THE FOLLOWING BOOSTER VACCINES BE ADMINISTERED: DTaP OR TDaP, POLIO, MMR, AND HEPATITIS B. A PHYSICIANS LETTER WILL BE REQUIRED VERIFYING THE ADMINISTRATION OF THE VACCINES.

STUDENTS ARE NOT ALLOWED TO CARRY MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER, IN THEIR PERSONAL BELONGINGS WHILE AT SCHOOL. IF YOUR CHILD NEEDS TO TAKE MEDICATIONS, OTHER THAN THOSE LISTED BELOW DURING THE SCHOOL DAY, PLEASE COMPLETE AND RETURN TO THE SCHOOL NURSE, THE MEDICATION AUTHORIZATION FORM FOUND ON THE ACST SCHOOL NURSE WEBSITE.

PERMISSION TO GIVE MEDICATION: / اذن إعطاء هذه الأدوية في المدرسة

please indicate yes or no next to each medication that may be given by the school nurse to your child during the school day

MEDICATION	YES	NO	USED TO TREAT
IBUPROFEN			NON-ASPIRIN PAIN RELIEVER, ANTI-INFLAMMATORY
ACETAMINOPHEN			NON-ASPIRIN PAIN RELIEVER, FEVER REDUCER
ANTACID			RELIEVES STOMACH UPSET AND GAS PAINS
COUGH SYRUP			NON-DROWSY COUGH RELIEF
THROAT LOZENGE			SORE THROAT RELIEF
ANTIHISTAMINE			NON-DROWSY ALLERGY RELIEF
DECONGESTANT			NON-DROWSY RELIEF FOR NASAL CONGESTION

PERMISSION TO GIVE EMERGENCY TREATMENT: / اذن إعطاء أدوية إستعجلية

IN THE EVENT OF AN EMERGENCY WHEN IMMEDIATE OBSERVATION OR TREATMENT IS DEEMED NECESSARY IN THE JUDGEMENT OF THE SCHOOL NURSE/AUTHORITIES, I AUTHORIZE AND DIRECT THE SCHOOL TO SEND MY CHILD TO THE MEDICAL FACILITY MOST READILY ACCESSIBLE. I SHALL NOT HOLD ACST OR THE SCHOOL AUTHORITIES LIABLE FOR ANY EXPENSES, CLAIMS, LOSS OR DAMAGE THAT MAY ARISE AS A RESULT OF SUCH ACTION AND SHALL INDEMNIFY THE SCHOOL FOR ALL EXPENSES, LOSSES, AND CLAIMS INCURRED BY IT IN RELATION TO SUCH ACTION.

PARENT/GUARDIAN SIGNATURE: / إمضاءالأولياء **DATE:**

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL NURSE IN WRITING OF ANY CHANGES TO THE INFORMATION GIVEN IN THIS FORM e.g. change of address, telephone number, physical condition or medications, or emergency contact.