

FOR OFFICIAL USE ONLY

PLEASE PASTE RECENT
PASSPORT SIZE PHOTO OF
APPLICANT HERE
(ONE OF FOUR COPIES)

STUDENT #

GRADE

ACADEMIC YEAR

PARENTAL APPROVAL TO ADMINISTER HEALTH CARE AT SCHOOL

NAME OF APPLICANT (BLOCK LETTERS)

FIRST

MIDDLE (if applicable)

FATHER'S NAME (if applicable)

FAMILY or LAST NAME

Home Phone #

Gender: Female Male

Mother's Phone #

Date of birth (MM/DD/YY)

Father's Phone #

PERSONS TO INFORM IN LEBANON IN CASE OF EMERGENCY IF PARENTS OR GUARDIANS ARE UNREACHABLE:

1. Name Relation Home Phone # Mobile #

2. Name Relation Home Phone # Mobile #

Doctor's Name

Phone # (s)

The school will not administer any medicines or screening to children without written permission from their parents. We urge you to complete this form as accurately as possible and return it with the application. Should you need any clarifications, please do not hesitate to call our nurses: Ms. Mattar (ext. 1122) and Ms. Halawi (ext. 1111).

- Yes, the school nurse has my permission to give my child over-the-counter medicines (e.g. analgesia, antipyretic, cough medicines, and throat lozenges) or antiseptic agents for wounds (in case needed).
- Yes, if any child or legal ward of mine enrolled at ACS appears to require immediate medical treatment and/or surgery where neither my spouse nor I are available to authorize a doctor to proceed therewith, I authorize the Head of School, or, in his absence or inability to act, the Deputy Head of School, to take whatever action is deemed necessary to ensure the provision of any necessary permit or authorization.
- Yes, I hereby authorize the school nurse to release information contained in this document to other health professionals or school administrators whenever it is medically needed for the care of my child.

Information requested herein in addition to the school screening examination are done in order to ensure that our students are at their maximal learning capacity and able to participate in the various school activities. They are not a replacement for your child's physician's medical assessment.

- Yes, the school nurse has my permission to perform a physical screening (height and weight measurements, dental, and vision check) for my child.

BLOOD TYPE OF CHILD: A+ A- B+ B- AB+ AB- O+ O-

STUDENT MEDICAL HISTORY (TO BE COMPLETED BY PARENT/GUARDIAN)

1. HISTORY:

Check any of the following the student has or may have had (please note: none of the information on this form will be used in admissions decisions):

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal bleeding/bruising | <input type="checkbox"/> Dislocation (shoulder, etc.) | <input type="checkbox"/> Positive PPD (Tuberculosis skin test) |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Eczema | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Allergies
(medications, bee sting, pollen, food, etc.) | <input type="checkbox"/> Eye or vision problems | <input type="checkbox"/> Scoliosis (curvature of spine) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting with or without exercise | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Gastrophageal reflux disease (GERD) | <input type="checkbox"/> Sickle-cell disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Single organs (kidney, eye, etc.) |
| <input type="checkbox"/> Broken bones/stress fracture | <input type="checkbox"/> Heart murmur/palpitations | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heat stroke or heat exhaustion | <input type="checkbox"/> Sudden death in the family before age 35 |
| <input type="checkbox"/> Chest pain during exercise | <input type="checkbox"/> Hepatitis/jaundice | <input type="checkbox"/> Sudden death in the family before 50 |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Concussion or head injury | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Undescended testicle |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Learning difficulty | <input type="checkbox"/> Wheezing or cough during or after exercise |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Fine gross motor skills difficulties |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Loss of eye sight | |

If any of the above is checked, please explain or attach a medical report:

Date of diagnosis: Treatment:

2. SURGERY:

Type Body Site Date

3. IMMUNIZATIONS

VACCINE	Date Administered First dose	Date Administered Second dose	Date Administered Third dose	Date Administered Fourth dose
Hepatitis B (Hep B)				
Penta (DTP, Hib, HepB)				
IPV (Inactivated Polio Vaccine)				
Rotavirus				
OPV (Oral Polio Vaccine)				
PCV13 Pneumococcal vaccine)				
Measles				
MMR (Measles, Mumps, Rubella)				
Hepatitis A				
Varicella				
Meningococcal (MCV4)				
COVID 19 vaccine				
Others				

4. Does the student have any other medical condition about which ACS should be informed? Yes No

If yes, please explain:

5. Is your child taking medication(s)? Yes No If yes, please list and for what reasons:

Medication name:	Dose:	Frequency/Times per day:	Reason(s):
a.
b.
c.

6. Does your child have allergies to medications? Please list.

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7. Any other allergies? Yes No If yes, type and discription of symptoms:

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8. Does your child wear glasses or contacts ? Yes No

9. Does your child have a prosthesis (medical device)? Yes No

If yes, please specify:

.....

My signature acknowledges that I have read and understood all the above.

.....
Signature (Parent or Guardian) Date

ACS BEIRUT - ADMISSIONS OFFICE
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