ACS BEIRUT

MEDICAL FORM

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**

Date of birth (MM/DD/YY)

Gender: ☐ Female ☐ Male

Home Phone #

Mother's Phone #

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-

Revised November 2021

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):

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

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

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Date of diagnosis: ..... Treatment: .....

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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.

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

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

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