SAGESSE HIGH SCHOOL
MARY MOTHER OF WISDOM
AIN SAADEH - METN - LEBANON

Student's Medical Form

This form should be filled by the child's pediatrician/family doctor.

I. Identification:

Name _____
Family *First* *Middle (if applicable)* *Father*

Gender Male ☐ Female ☐

Date of Birth (Day/Month/Year)_____

Grade _____

Blood Type_____

II. Contact details:

Mother's Name_____ Mother's mobile number _____

Father's Name_____ Father's mobile number _____

House phone number _____

Guardian's Name _____ Guardian's mobile number_____

Person(s) to inform in case of emergency if parents/guardians are unreachable:

Name _____ Relation _____ Phone number _____

Name _____ Relation _____ Phone number _____

III. Personal Health History:

Did the child suffer or is currently suffering from any of the following conditions? If yes, please specify

Condition	No	Yes	Specify
Abdominal/stomach/digestive problems			
Allergy to medicine			
Anemia			
Asthma			
Behavioral problems			
Bleeding problems			
Bone fracture/dislocation			
Breathing problem			
Cancer			
Chest pain during exercise			
Chicken pox/measles			
Chronic bronchitis			
Congenital heart disease			
Depression			
Developmental problem			
Diabetes			
Ear problem			
Ear surgery			
Eating disorder			
Eczema			
Epilepsy			
Excessive fatigue			
Exercise induced asthma			
Eye/vision problems			
Febrile convulsion			
Food allergy			
Gall bladder trouble			
Head injury/concussion			
Hearing problem			
Heart murmur			
Heart palpitation			
Heart problem			
Heat stroke/heat exhaustion			

Condition	No	Yes	Specify
Hepatitis/jaundice			
Hernia			
High blood pressure			
Hospitalization			
Insect allergy			
Kidney disease			
Menstrual problem			
Migraine/headaches			
Mumps			
Positive PPD			
Psychomotor problems			
Respiratory disease			
Scoliosis			
Seasonal allergy			
Seizures			
Single organ			
Sinus problem			
Skin allergy			
Sleep disorders			
Speech problem			
Spinal injury			
Surgery			
Thyroid disease			
Undescended testicles			
Other			

Is the child capable of physical activity? If No, Why?

_____

_____

Is the child currently taking any medication?

Medication: _____Dosage: _____Reason:_____

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Medication: _____Dosage:_____Reason:_____

List any medication that the child is required to take during field trips.

Medication: _____ Dosage: _____

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IV. Immunization

The following immunizations are required by the Ministry of Health. Indicate the date of the immunization and the next booster in each case.

Vaccination	Date of the immunization	Next Booster (if applicable)
Tetanus		
Pertussis		
Diphtheria		
Measles		
Mumps		
Rubella		
Poliomyelitis		
Chicken Pox		
Hepatitis B		

N.B. Parents are kindly asked to update the medical record whenever changes occur.

This form has been filled by

Doctor's Name: _____

Doctor's Signature: _____

Doctor's Contact Number: _____

To be signed by parent /guardian

I, hereby, authorize

- the school nurse to administer over-the-counter medicines (e.g. analgesia, antipyretic, cough medicine, throat lozenges…) or antiseptic agents for wounds.

- the school nurse to release information contained in this document to other health professionals or school administration whenever it is medically necessary for the care of my child.

- the school medical staff to perform a screening exam (height, weight measures, dental, vision, etc., check) on my child when such screening is taking place.

- the doctor selected by the school to secure and administer treatment, including hospitalization, for my child in case I cannot be reached in an emergency.

Signature of Parent/Guardian **Date**

_____ _____