SAGESSE HIGH SCHOOL

Mary Mother of Wisdom

Ain Saadeh - Metn, Lebanon

PLEASE PASTE RECENT PASSPORT SIZE PHOTO OF APPLICANT HERE

Medical Form

PARENTAL APPROVAL TO ADMINISTER HEALTH CARE AT SCHOOL

Name of student: _____
Family First Middle Father's Name

Birth Date _____ Age _____ Gender _____ Grade _____ Blood Type ☐
Day/Month/Year

Home Phone Number _____ Mobile Phone Number _____ Emergency Phone Number _____

Name of Pediatrition or Family Doctor _____
Full Name Clinic Phone

Person(s) to contact in case of emergency if parents or guardians are unreachable:

Name _____ Relation _____Telephone Number _____

Name _____ Relation _____Telephone Number _____

The school will not administer any medication nor provide any health care or screening to children without written permission from their parents. Please complete this form and return it with the application. For clarifications, do not hesitate to contact our school nurse.

I, hereby, authorize

- the school nurse to administer **over-the-counter medicines** (e.g. analgesic, antipyretic, cough medicines, 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.) 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.

Please complete this form as accurately as possible. Information requested herein and the school screening examination are not a replacement of your child's physician's medical assessment.

Family Doctor's Name (If the doctor filled the form)

_____

Family Doctor's Signature:

_____

Signature acknowledges that we have read and understood all the above:

_____
Parent's / Guardian's Name Parent's / Guardian's Signature Date

STUDENT'S MEDICAL RECORD

1- History: Complete (parent / guardian or family doctor)

Check any of the following the student has or may have had: *

- ☐ Abnormal bleeding/bruising
- ☐ Allergy(ies) (medications, bee sting, pollen, etc...)
- ☐ Anemia
- ☐ Asthma
- ☐ Broken bone(s)/stress fracture
- ☐ Chest pain during exercise
- ☐ Chicken Pox
- ☐ Concussion or head injury
- ☐ Diabetes
- ☐ Dislocation (shoulder, etc.)
- ☐ Hearing problem
- ☐ Eye or vision problems
- ☐ Fainting with or without exercise
- ☐ Hearing impairment
- ☐ Heart murmur/palpitations
- ☐ Heat stroke or heat exhaustion
- ☐ Hepatitis/Jaundice
- ☐ High blood pressure
- ☐ Hospitalization
- ☐ Loss of eye sight
- ☐ Measles
- ☐ Mumps
- ☐ Positive PPD (Tuberculosis skin test)
- ☐ Renal problem(s)
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scoliosis (curvature of spine)
- ☐ Seizures
- ☐ Sickle-cell disease
- ☐ Single organ(s) (kidney, eye, etc.)
- ☐ Skin problems
- ☐ Hypoglycemia
- ☐ Sudden death in the family before age 35
- ☐ Sudden death in the family before age 50
- ☐ Surgery(ies)
- ☐ Tuberculosis
- ☐ Undescended testicles
- ☐ Wheezing or coughing during or after exercise

Please give dates and explanation for the checked issues in the space provided below: *
(Use extra sheet if needed)

_____

_____

2-Immunization: Attach copy of recent vaccination records or complete the following:

	Date of First	Date of Booster	Date of Next Booster
Diphteria	_____	_____	_____
Tetanus	_____	_____	_____
Pertusis	_____	_____	_____
Poliomyelitis	_____	_____	_____
Measles	_____	_____	_____
Mumps	_____	_____	_____
Rubella	_____	_____	_____

3-Medications: Check in case your child is taking any of the following medications and write the doses given.

- ☐ Ritalin Dose: _____
- ☐ Depakene Dose: _____
- ☐ Ventolin Dose: _____
- ☐ Other, please specify _____

_____

Parent's/Guardian's signature verifying above information

_____

Parent's / Guardian's Name | Parent's / Guardian's Signature | Date