ACST MEDICAL EXAMINATION FORM

PHOTO

- 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.

PERSONAL AND CONTACT INFORMATION

STUDENT NAME

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

ADDRESS IN TUNISIA: .....

	MOBILE NUMBER	WORK PHONE NUMBER
MOTHER/GUARDIAN 1		
FATHER/GUARDIAN 2		

NAME OF PHYSICIAN IN TUNISIA: ..... **PHYSICIAN PHONE NUMBER:** .....

EMERGENCY CONTACT NAME: ..... **EMERGENCY CONTACT RELATIONSHIP:** .....

EMERGENCY CONTACT PHONE NUMBER: .....

MEDICAL HISTORY to be filled out by a physician

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

..... **DATE** ...../...../.....

VACCINATIONS (photocopy of immunization card preferred) / التطعيمات

THE IMMUNIZATION LISTED BELOW ARE MANDATORY FOR ADMISSION TO ACST							REMARKS
DPT*							
TETANUS							
POLIO							
MEASLES*							
RUBELLA*							
HEPATITIS B							
COVID-19: 12years up							
Optional:							
CHICKEN POX							
BCG*							
COVID-19 < 12 years							

**DPT: DIPHTHERIA, PERTUSSIS, and TETANUS also known as DTaP or TDaP / BCG*: Vaccine against Tuberculosis*

**MEASLES, MUMPS and RUBELLA may be given as the combined vaccine MMR*

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

STUDENT ALLERGY INFORMATION

Does your child have an allergy? .....**YES** .....**NO**

Symptoms to allergy includes:

..... HIVES, ITCHY RASH

..... SWELLING AROUND EYES, FACE OR EXTREMITIES

..... ITCHING OR TIGHTNESS IN THE THROAT

..... HOARSENESS

..... NAUSEA, ABDOMINAL CRAMPS, VOMITING OR DIARRHEA

..... SHORTNESS OF BREATH

..... WHEEZING

..... FAINTING, WEAK PULSE, "PASSING OUT"

Does your child have medication for allergies? .....**YES** .....**NO**

MEDICATION	DOSE	ANY FURTHER INFO	Y/N PROVIDING MEDICATION

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: / إذن 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			RELIVEVES 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: / إذن إعطاء أدوية استعجالية

IN THE EVENT OF AN EMERGENCY WHEN IMMEDIATE OBSERVATION OR TREATMENT IS DEEMED NECESSARY IN THE JUDGMENT 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: / إمضاء الأولياء **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.