

## GWA Mandatory Medical Form

Parents/guardians please complete -

Student's Name: First \_\_\_\_\_ Last \_\_\_\_\_ Date of birth: \_\_\_\_\_

Daily Medications (name, dose, frequency): \_\_\_\_\_

Allergies (medications, environmental or dietary; if student has food allergies please complete a separate *GWA Food Allergy Form*): \_\_\_\_\_

Does student require medication to be present during the school day? (asthma inhaler, epi-pen, etc): \_\_\_\_\_

**\*Required Vaccinations: Please enter the date each vaccine was administered - MM/DD/YYYY**

Diphtheria/Tetanus/Pertussis/Poliomyelitis/Hib (if given as separate vaccines please provide records of all to the nurse office)

1	2	3	4
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Measles/Mumps/Rubella

1	2
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**\*All required vaccines are MANDATORY before entry to GWA. Medical exemptions must be provided by a physician and religious exemptions must be provided by parents, in writing to the nurse office.**

**Optional Vaccinations:**

BCG (Tuberculosis)

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Hepatitis A

1	2
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Hepatitis B (strongly recommended)

1	2	3
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Influenza (strongly recommended; especially for students with asthma and other chronic medical conditions)

1	2	3
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Meningococcal Meningitis

1	2
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Pneumococcal Conjugate (strongly recommended)

1	2	3	4
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Varicella (strongly recommended)

1	2
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If a student had chickenpox diagnosed by physician, date: \_\_\_\_\_

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If your son/daughter has NOT received a BCG vaccine we require one of the following within the past year ***prior to initial entry to GWA:***

- Tuberculin Skin Test (TST)/PPD test
- Quantiferon blood test OR
- Chest x-ray

\*\*Please provide a copy of the above test result to the GWA nurse office staff.

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**I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for the medical staff at GWA to treat my son/daughter to the best of their ability and the exchange of medical information from healthcare providers if necessary.**

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician please complete the following -**

Height (cm):	Pulse:
Weight (kg):	Blood Pressure:

Body System	Normal	Abnormal/ Defer	Abnormal findings/recommendations:
Hair/Scalp			
Skin			
Eye/vision			
Ears/hearing			
Nose and throat			
Teeth and gingiva			
Lymph glands			
Heart/cardiovascular			
Lungs/respiratory			
Abdomen			
Genitourinary			
Neuromuscular			
Extremities			
Spine (scoliosis)			
Other			

Known medical conditions (including those which require medication, follow up, restriction of activity or may impact academic performance): \_\_\_\_\_

\_\_\_\_\_

Prior hospitalizations or surgeries (please provide diagnosis and dates): \_\_\_\_\_

\_\_\_\_\_

By signing or stamping below; ***I confirm that this child is in good medical health and is able to participate in school sports, after school physical activities and physical education class.***

Physician Name (printed): \_\_\_\_\_

Contact Information (address, phone): \_\_\_\_\_

\_\_\_\_\_

## GWA Tuberculosis Screening

Tuberculosis is an endemic, major, public health concern in Morocco. Receiving the BCG vaccine at birth does not have proven long-term efficacy at preventing active tuberculosis disease for life. In an effort to maintain a high standard of health at GWA we require completion of this tuberculosis screening for *all new students, 1st, 4th, 7th and 10th graders.*

### Tuberculosis Screening Questions

Has the student had a persistent cough > 4 weeks with any of the symptoms:

- Night sweats/fever
- Bloody sputum
- Weight loss/fatigue
- Direct contact with a TB infected person

If YES to any symptoms above; GWA requires a chest xray to be completed prior to attending class.

Chest xray date: _____	Result: _____	Healthcare Provider/Clinic: _____
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- This student does not have any of the above listed symptoms or any known risk factors for a possible active TB infection.

Physician signature: \_\_\_\_\_

Date of exam: \_\_\_\_\_