GWA Mandatory Medical Form

Parents/guardians please complete -

Student's Name: First _____ Last _____ Date of birth: _____

Daily Medications: _____

_____

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**

Diptheria/Tetanus/Pertussis/Poliomyelitis/Hib

1	2	3	4

Tetanus/Diptheria/Pertussis Booster (usually at 11-12 years of age)

1

Measles/Mumps/Rubella

1	2	3

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

Optional Vaccinations:

BCG (Tuberculosis)

Hepatitis A

1	2

Hepatitis B (strongly recommended)

1	2	3

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

1	2	3

Meningococcal Meningitis

1	2

Pneumococcal Conjugate (strongly recommended)

1	2	3	4

Varicella (strongly recommended)

1	2

If chickenpox diagnosed by physician, date: _____

Subjective Health History - *Parents/guardians please complete with the student's physician ...*

General Health: Has the student ...	Yes	No
Any chronic medical conditions?		
Ever been hospitalized?		
Ever had surgery?		
Been born without or is missing an organ?		
Had frequent muscle cramps when exercising?		

Genitourinary: Has the student ...	Yes	No
Had groin pain or hernia?		
Had a history of urinary tract infections?		
Females: started menstruation?		
If yes, date of first menstrual period?		

Head/Neck/Spine: Has the student ...	Yes	No
Had frequent or severe headaches?		
Ever had a head injury or concussion?		
Noticed or been told they have a curved spine (scoliosis)?		
Had any vision problems or eye trauma?		
Been prescribed glasses or contact lenses?		
Date of last eye exam:		

Dental: Has the student ...	Yes	No
Had any pain or chronic problems with their teeth or gums?		
Date of last dental cleaning/exam:		

Heart/Lungs: Has the student ...	Yes	No	**Social/Learning:** Has the student ...	Yes	No
Ever used an inhaler or taken asthma medicine?			Been told he/she has a learning disorder, cognitive delay or ADD/ADHD?		
Ever been told they have a heart condition?			Experienced major trauma or grief?		
Had any cardiac testing done (ECG, echocardiogram)?			Exhibited major changes in behavior, relationships, grades or eating/sleeping patterns?		
Had chest pain, tightness, discomfort or pressure during exercise?			Been worried, sad/depressed, or angry for long periods of time?		
Felt his/her heart race or palpitate during exercise?			Shown a general loss of energy, motivation, enthusiasm or interest in life?		
Felt light headed or dizzy during or after exercise?			Been actively trying to lose or gain weight?		

Bone/Joint: Has the student ...	Yes	No	**Skin:** Has the student ever …	Yes	No
Had a broken/fractured bone or dislocated joint?			Had any chronic rashes, sores or skin problems?		
If yes, which bone and when?			Ever had herpes (cold sores) or a MRSA skin infection?		
Had an injury to a tendon, ligament or muscle?					
Had joints that become swollen, painful, red or warm?					

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 affect academic performance): _____
_____
_____
Additional Comments: _____
_____
_____
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: _____

- ❑ 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: _____

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.
