



RABAT AMERICAN SCHOOL STUDENT HEALTH INFORMATION ANNUAL UPDATE

PART 1: Identifying Data (To be completed by parents or guardian) – PLEASE PRINT

Last Name: _____ First Name: _____ Grade: _____ School Year: _____

Age: _____ Date of Birth: ___/___/___ Sex: Male ___ / Female ___

Home Ph: () _____ Father's Work Ph: () _____ Mother's Work Ph: () _____

Home Email: _____ Father's Email: _____ Mother's Email: _____

Parent or Guardian Name (Print): _____ Signature: _____

Physician's Name in Morocco: _____ Phone number: _____

In case of emergency which hospital or clinic in Rabat should your child be sent?

Hospital: _____ Clinic: _____

My child has a medical condition that may affect his or her school day: _____ No / _____ Yes (if yes, please complete part 2 below.)

PART 2: Please complete all boxes that apply to your child. The Parent or guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Please see the school nurse to complete the necessary forms for bringing medications to school.

_____ Allergies

_____ Food (Please list): _____

_____ Bee sting

_____ Other (Please list): _____

Reactions (Please check):

<input type="checkbox"/> Coughing	<input type="checkbox"/> Hives	<input type="checkbox"/> Rash
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Local swelling	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Nausea	<input type="checkbox"/> General swelling	<input type="checkbox"/> Other:

Currently Prescribed treatments to be used at school: _____

_____ Asthma

Triggers: _____ Exercise _____ Environmental _____ Other (list): _____

Physical / Activity Restrictions: _____ None _____ Self-limits _____ Other: _____

Symptoms (Please check):

<input type="checkbox"/> Coughing	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Chest tightness, discomfort, pain
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Other:
<input type="checkbox"/> Throat itch, tightness, soreness		

Currently Prescribed treatments to be used at school: _____

Date of last hospitalization related to asthma: _____

_____ Other Health Conditions

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Other:
<input type="checkbox"/> Diabetes		

Physical / Activity Restrictions: _____ No / _____ Yes (list): _____

Currently Prescribed treatments to be used at school: _____

(Part 3 on the reverse side)

PART 3: Please update any immunizations received during the last year.

IMMUNIZATION	Date	
Diphtheria, Tetanus, Pertussis (DTP, DTaP)		
Tdap Booster		
Poliomyelitis (IPV, OPV)		
Hemophilus influenza Type b (Hib Conjugate) (for children under 60 months of age)		
Pneumococcal (PCV conjugate) (for children under 2 years of age)		
Measles, Mumps, Rubella (MMR vaccine) (REQUIRED for entry to RAS)		Or serological Confirmation of Measles Immunity Date:
Hepatitis B Vaccine (HBV)		
Hepatitis A Vaccine		
Varicella Vaccine		Date of Varicella (chicken pox) Disease or Serological Confirmation of Varicella Immunity:
Other		
Other		

Print name of parent or guardian

Signature of parent or guardian

Address (if different from above)

Work phone

Date