RABAT AMERICAN SCHOOL (For: Entry to RAS and/or Athletic Pre-participation)
STUDENT HEALTH HISTORY / PHYSICIAN'S EXAMINATION

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

Last Name: ______________________________ First Name:_________________________ Grade: __________ Age:___________

Date of Birth: _____/_____/_____ Blood Type: _________ Sex: Male / Female

Home Address in Morocco: Street: ____ City/Area: _____ _______________________________

Home Ph: ( )_______________ Father's Work Ph: ( )_______________ Mother's Work Ph: ( ) _____________________

Home Email: ______________________ Father's Email: _________________________ Mother's Email:_____________________

Physician's Name in Morocco: ____ Phone number: _______________________________

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

Hospital: ____________________________________ Clinic: ____

I. HEALTH HISTORY (Must be completed by a parent prior to the physician's examination)

Yes	No	
☐	☐	Have you had a medical illness or injury since your last physical?
☐	☐	Do you have an on-going or chronic illness ?
☐	☐	Have you been hospitalized overnight?
☐	☐	Have you ever had surgery?
☐	☐	Are you currently taking any medications, using an inhaler?
☐	☐	Have you taken any supplements to improve performance, or gain or lose weight?
☐	☐	Do you have any allergies (pollen, medicine, food, stinging insects)? Have you ever developed a rash or hives during or after exercise?
☐	☐	Have you ever experienced dizziness or fainting with exercise?
☐	☐	Have you ever had chest pain during or after exercise
☐	☐	Have you ever had a racing heartbeat or had skipped heartbeats?
☐	☐	Have you ever been told you have a heart murmur?
☐	☐	Do you have high blood pressure or high cholesterol?
☐	☐	Has any family member or relative died of heart problems or of sudden death before age 50?
☐	☐	Has a physician ever denied or restricted your participation in sports for any heart problems?
☐	☐	Have you had a severe viral infection (such as myocarditis or mononucleosis) within the last month?
☐	☐	Do you have any current skin problems (such as itching, rashes, acne, warts, fungus or blisters)?
☐	☐	Have you ever had a head injury or concussion?
☐	☐	Have you ever been knocked out or lost consciousness?
☐	☐	Have you ever had a seizure?
☐	☐	Have you ever had numbness or tingling in your arms, hands, legs or feet?
☐	☐	Do you cough, wheeze, or have trouble breathing during or after activity?

Yes	No	
☐	☐	Do you have asthma?
☐	☐	Do you use an inhaler before exercise?
☐	☐	Do you have seasonal allergies requiring medical treatment?
☐	☐	Do you use any special protective or corrective device (knee or ankle brace, retainer on teeth, hearing aid) not usually worn for your sport or other activity?
☐	☐	Have you had any problems with your eyes or vision?
☐	☐	Do you wear glasses, contacts or protective eyewear?
☐	☐	Has a doctor ever told you or a family member that you are at risk for blood disorders?
☐	☐	Were you born without or are you missing a kidney, testicle or any other organs?
☐	☐	Do you feel that you have fatigue or increased shortness of breathe with activity?
☐	☐	Do you have any concerns that you would like to discuss with a doctor?
FEMALES ONLY		
☐	☐	Have you begun menstruation?
☐	☐	If yes, are ever experiencing any problem (such as irregularity, pain, etc.)?

Have you ever had a sprain, strain, fracture or dislocation of a muscle, tendon, bone or joint? *If yes, check appropriate box and explain below.*

☐	Head	☐	Elbow	☐	Hip
☐	Neck	☐	Forearm	☐	Thigh
☐	Back	☐	Wrist	☐	Knee
☐	Chest	☐	Hand	☐	Shin/calf
☐	Shoulder	☐	Finger	☐	Ankle
☐	Upper Arm			☐	Foot

Use this space to explain any **YES** answers to the above questions: ____

____

_ ____

Additional explanations (from page 1) / Other comments & information: ____

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II. IMMUNIZATION RECORDS

TB Test Result (REQUIRED for entry to RAS): Please attach proof of and results from one of the following:

PPD (skin test), Date: ____________, or

Chest X-Ray, Date: _____________. (also required for those who have had BCG Vaccination or those who otherwise cannot have a PPD)

NOTE: For Athletic pre-participation annual physicals, complete only if information has changed or if additional immunizations have been received. Yearly PPDs are suggested, but not required.

IMMUNIZATION	RECORD COMPLETE DATES (month/day/year) OF VACCINE DOSES GIVEN				
Diptheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	
Tdap Booster	1				
Poliomyelitis (IPV, OPV)	1	2	3	4	
Hemophilus influenza Type b (Hib Conjugate) (for children under 60 months of age)	1	2	3	4	
Pneumococcal (PCV conjugate) (for children under 2 years of age)	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine) (REQUIRED for entry to RAS)	1	2	Or serological Confirmation of Measles Immunuity Date:		
Hepatitis B Vaccine (HBV)	1	2	3		
Varicella Vaccine	1	2	Date of Varicella (chicken pox) Disease or Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Other	1	2	3	4	5
Other	1	2	3	4	5

Physician's Verifying Signature (if original documents not attached): ____

Parent's or Guardian's Acknowledgement:
I reviewed and completed the form. The information provided is true to the best of my knowledge.

____

Print name of parent or guardian | Signature of parent or guardian

____

Address (if different from above) | Work phone | Date

RABAT AMERICAN SCHOOL (For: Entry to RAS and/or Athletic Pre-participation)
PHYSICIAN'S EXAMINATION

Part 2: **General examination (To be completed by the examining physician prior to entry to RAS, prior to grade 6, prior to grade 9, and annually for participation in sports/intramurals from grades 5-12)**

Student Name: ______________________________________ **Date of Birth:** ___________________________

Height: _____________ **Weight:** _______________ **Pulse:** ________________ **Blood Pressure:** ___________________

Vision: _____________ **R 20/**_____ **L 20/**_____ **Corrected: Yes** _____ **/ No** _____ **Pupils: Equal** _____ **/ Unequal** _____

	NORMAL	**ABNORMAL FINDINGS**	**INITIAL**
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Hip/Thigh			
Knee/			
Leg/Ankle			
Foot			

RECOMMENDATIONS (check one):

	Unlimited participation		Clearance withheld pending further evaluation (see comments)		Participation limited to specific sports (see comments)		No athletic participation (see comments)

COMMENTS: ____

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Provider's Name: (MD/DO/NP/PA) ______________________________ Date: ______________________________

Signature: ____