Medical Record Form
201_ / 201_
*** Must be returned on your child's first day at the ECC***

CHILD INFORMATION

Name: _____ _____ _____
(First) (Father) (Family)

Gender: Male ◯ Female ◯ Blood Type: _____

Date of Birth: _____ _____ _____
(Day) (Month) (Year)

Home Phone(s): _____ _____

HEALTH HISTORY

Please check if the child **has or may have had** any of the following:

- ☐ Abnormal bleeding / bruising
- ☐ Anemia
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Dislocation (shoulder, etc.)
- ☐ Ear Problems
- ☐ Eye or Vision Problems
- ☐ Hepatitis
- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other

If any of the above is checked, please explain:

_____
_____
_____

Did the child have any previous operation and/or severe injury? If yes, please explain:

_____
_____
_____

SIGNIFICANT PROBLEMS

Does the child have any medical condition about which the ECC should be informed? If yes, please explain:

_____
_____
_____

Is the child taking any medication? If yes, please list:

_____
_____
_____

Please list any drug / food / beverage that the child is allergic to:

_____

_____

_____

Does the child have a physical disability? If yes, please describe it in details:

_____

_____

_____

Does the child have any special medical problem requiring limitations on his/her physical activity? If yes, please describe it in details:

_____

_____

_____

IMMUNIZATIONS

Please indicate the **last date of vaccination** for the following:

Required by the Ministry of Public Health in Lebanon	
Hepatitis B	
Polio, Diphtheria, Pertusis, Tetanos Hemophilus	
Measles, Mumps, Rubella (MMR)	
Tuberculin test (PPD)	
Recommended	
Rota Virus	
Pneumococcus	
Meningococcus	
Hepatitis A	
Chickenpox / Varicella	
Optional	
BCG (Tuberculosis) – Optional	
Typhoid – Optional	

Physician's Name: _____ Physician's Signature: _____

Physician's Number(s): _____ _____

Date: _____

Medical Consent Form

In the event that my child, _____ becomes ill or sustains an injury while attending the ECC, I give permission to the ECC nurse to administer First Aid. I consent to a medical diagnosis and treatment, as well as any medications necessary while under the care of the nurse. I do understand that this form will apply to all future emergency situations and a copy of this form is as valid as the original. This consent form will remain in effect throughout the academic year.

Parent's Name: _____ Parent's Signature: _____

Date: _____