

Medical Certificate

School Year 2026/2027

To be completed exclusively by the child's pediatrician and returned in a sealed envelope to the high school.

Confidential information will be kept by the Health Department.

Student's name and surname :

Father's name : **Mother's name :**

Year of birth : **Blood type :**

Class :

Write down the last vaccination date of :	
1- OPV	Date : / /
2- Triple vaccine (DPT)	Date : / /
3- Measles- Mumps –Rubella (MMR)	Date : / /
4- B.C.G (TB)	Date : / /
5- Tuberculin (test) PDD, IDR	Date : / /
6- Meningitis (what type)	Date : / /
7- Chickenpox	Date : / /
8- Hepatitis	Date : / /
9- Other	Date : / /

Medical and Surgical History :

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Current Long-Term Treatment :

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Fitness for Sports :

- Fit
- Unfit : Duration Reasons
- Precautions to take :

The clinical examination reveals :

	Treatment	Dose
Allergies		
Asthma		
Diabetes		
Epilepsy		
Heart problem		
Respiratory problem		
Neurological problem		
Digestive problem		
Motor problem		
Urinary problem		
Hearing problem		
Eye problem		

Authorisation to administer the following medications at the High School:

Name	Form	Yes	No
Motilium	Syrup		
Buscopan 100 mg	Tablet		
Panadol Advance	Tablet		
Panadol Blue > 5 ans	Syrup		
Panadol Pink < 5 ans	Syrup		
Fenistil	gel		
Fucidin	Cream		
Mebo	Cream		
Voltaren	Gel		
Arnica	Gel		

Parents are responsible for any unreported illness(es).

Parent's Signature

Date and Pediatrician's stamp

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