MEDICAL FORM 2 (PART 1)

Please have your **physician/medical doctor** **(MD or DO only - not PAC/FNP/APRN/NP/RN)** fill out, sign and stamp this form. Scan and upload to ACG blackboard platform at least three weeks before the beginning of classes. Please direct questions or concerns to wellnesscenter@acg.edu.

Please note that due to strict Greek laws, ACG can only accept this form from a Medical Doctor or Doctor of Osteopathy (MD or DO). The **Greek Law does not recognize other health care professionals** such as Nurse Practitioner or Advanced Practice Registered Nurse (APRN), Certified Pediatric Nurse Practitioner (CPRN), Family Nurse Practitioner (FRNP), Physician Assistant Certified (PAC), Doctor of Chiropractic (DC).

MEDICAL HISTORY / ATHLETICS / COCURRICULAR ACTIVITIES

COMPLETED BY PHYSICIAN

Last Name ______________________________________**First Name** __________________________

Email:______________________________ **Date of Birth (day/month/year)** ___/ ___/_____

ACG Student ID#_____________________ **Dates attending ACG**___________________

SECTION A-MEDICAL HISTORY

Does the student have any of the following medical conditions? Please circle all that apply.

ADHD/Learning Disabilities	Diabetes	Heart Condition	Other life threatening conditions
Alcohol/Drug Abuse	Dietary Restrictions	Hospitalization	Physical Disability
Allergies	Eating Disorder	Hypotension/Hypertension	Psychiatric disorders
Anxiety/Depression	Endocrine Disorders	Kidney disease	Skin disorders
Asthma	Epilepsy/Seizure	Migraine	Suicide attempt
Blood Disorders	Gastrointestinal Disorders	Musculoskeletal problems	STIs/Other infectious diseases
Cancer	Gynecological issues	Operations	

Other – Please Specify

____

If YES, please fill out FORM 2 (PART 2) – INDIVIDUALIZED EMERGENCY CARE PLAN

SECTION B- PHYSICAL EXAMINATION AFFIRMATION - ATHLETICS

I have examined the student and have found this student is able to participate in physical education courses, and use the athletic facilities including the pool, track & field and the fitness center for recreational purposes. Additionally, I confirm that that I have examined this student and found that they do not suffer from any skin diseases that would prevent them from using the pool.

☐ **YES** ☐ **NO**, I do not give clearance for the above.

SECTION C- PHYSICAL EXAMINATION AFFIRMATION – PARTICIPATION IN CO-CURRICULAR ACTIVITIES

I have examined the student and have found this student is able to participate in co-curricular activities. ACG planned excursions include visits to mainland and island destinations some of may have medical facilities limited to a first aid station with a pathologist. Traveling involves transportation by bus and/or boat and physical activity such as, walking through ancient sites and museums in hot weather, moderate hiking, swimming, dancing etc.

☐ **YES** ☐ **NO**, I do not give clearance for the above.

Physician/Medical Doctor - MD or DO (not PAC/FNP/APRN/NP/RN)

Name____**Degree(MD/DO)**__________

Address____**City**________________________

Prefecture_____________________**Country**_____________________**Postal Code**__________

Telephone____**Email**______________________

Signature & Stamp Date

ACG Health & Wellness Center
6 Gravias Street, 153 42 Aghia Paraskevi, Athens, Greece
t: +30 210 600 9800, ext. 1500, 1700, 1193
wellnesscenter@acg.edu, www.acg.edu

MEDICAL FORM 2 (PART 2)

Please have your **physician/medical doctor fill out, sign and stamp** this form if you have any of the conditions listed under Medical History. Scan and upload to ACG blackboard platform at least three weeks before the beginning of classes. Please direct questions or concerns to wellnesscenter@acg.edu.

The information is collected with the sole purpose of ensuring the protection of the security and health of the students. Information is kept strictly private and confidential and stored by a nurse according to the provisions of the applicable legislation on personal data, including the Regulation (EU) 2016/679 of the European Parliament and of the Council as in effect from time to time (as described in the "Notification and Consent for the Processing of Personal Data" Form).

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INDIVIDUALILZED EMERGENCY CARE PLAN	
Physician's Order/Authorization for First Aid Services	
Student:	**Date of Birth:**
Please describe condition and treatment and/or learning disability for **Allergies, Asthma, Diabetes,** and **Seizures** please skip this section and proceed to pages 4-7.	
Medical treatment should be continued until (date): Hospitalizations/Operations:	
Precautions/Possible Adverse Reactions	
*Please include any medications that the student should **not** be administered.	

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Special Equipment Required (medical devices etc used and supplied by student)	
Special Dietary Requirements/Limitations	
Physical/Mental Limitations due to Health Condition and/or Medical Treatment	
Physical Limitations (mobility, stamina, transportation, hearing, vision, breathing/ventilation, toileting/hygiene, caring for oneself, performing manual tasks, physical education/athletics, field trips/events, etc)	**Mental Limitations** (attendance, academic testing, memory/attention, concentration, oral/written expression, articulation, peer interactions, personality, skills, etc)
Adjustments Requested at College and/or Dormitory	**Adjustments Requested at College and/or Dormitory**

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Allergies/Allergic Reaction	
Moderate Allergic Reaction	
Trigger Factors:	
Signs and Symptoms	**Intervention**
Severe Allergic Reaction (Anaphylactic Shock)	
Signs and Symptoms	**Intervention**

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Asthma Action Plan

Moderate Exacerbation

Trigger Factors:

Signs and Symptoms		Interventions
Cold like symptoms	☐	Continue control medications (as listed in page 1) and add: Yes ☐ No ☐
Moderate wheezing	☐	
Cough	☐	
Chest Tight	☐	
Difficulties in participating in activities	☐	
SPO2<__________	☐	**Medication:**
Tachycardia	☐	**Dosage:**
Other (define)	☐	

Diabetes

Insulin Administration Orders

Type(s) of Insulin:

Does the student have an insulin pen? Dosage

Does the student have an insulin pump? Will student self-administer? Dosage

Administration of Glucagon

In which cases should glucagon be administered? (symptoms and signs/blood glucose level):

Dosage:

Directions of administration:

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Seizures

Seizure type(s):

Average length: ____ **Frequency:** ______________________

Triggers, warnings and/or behavior changes before the seizure occurs:

Usual reactions after a seizure is over:

Do other illnesses affect student's seizure control? (please describe):

Rescue Medications/dosage:

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Physician Contact Details	
First name: **Surname:**	**Telephone numbers:**
Mailing Address:	
Email:	
Physician/Medical Doctor Authorization	
I, the undersigned ____Degree(MD/DO)____________, as the physician for ____ (student's name), verify that the procedures and treatments as described above are necessary to be performed during College activities and I approve the administration of medication by qualified designated staff of the College who will act accordingly.	
Signature and Stamp:	**Date:**

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