حكومة دبي
GOVERNMENT OF DUBAI

هيئة الصحة بدبي
DUBAI HEALTH AUTHORITY

Photo

Student Medical Form

Dear Parent or Guardian of the Student:

Please fill the attached form accurately in order to protect your son or daughter's health. If the answer is yes, please write the date and details in the comments cell. Accuracy is needed for us to be able to follow their health status. Best wishes for good health and wellness

School Information		
School Name:	Grade:	Class:

Student Information

Student Full Name: …… Gender: ……..…....

Date of Birth: …… Nationality: ……..

Parent or Legal Guardian Name: …… Relationship: ….....

Mobile Phone Number (1): …… Mobile Phone Number (2): ……

E-Mail: …… Emirate: ……

In case of Emergency and not being able to reach parents, the following person can be contacted:

Name: …… Relationship: …… Mobile Phone Number: ….....

Required Attachments (IN PUPIL FILE)

Student Emirates ID	Yes	No	ID Number:
Student Passport Copy	Yes	No	
Original Vaccination Card or updated colored copy (authorized)	Yes	No	
Health Card Number (if any)	Yes	No	Health Card Number:

Health Insurance Card (if any)	Yes	No	Health Insurance Card Number:

Medical History of the student

Is there any health problem, out of the following? If the answer is yes, please state the problem type and date in comments cell

	Health Problems	Yes	No	Comments
1	Any problem to drug, food, dust….			
2	Cardiovascular problem			
3	Diabetes			
4	Hypertension			
5	Asthma			
6	Renal Problem			
7	Epilepsy seizures or Convulsion seizures			
8	Epistaxis			
9	Hemolytic Anemia, type G6PD			
10	Hereditary Blood Disease (e. g. Thalassemia, sickle cell anemia, Hemophilia), Please specify if any			
11	Skin Problem			
12	Eye problem (Myopia, Hyperopia, ….), Please specify if any			
13	Hearing problem			
14	Any case that may weaken Immunity System such as Cancer (Blood cancer, Lymphoma), or transplantation, Please specify if any			
15	One of the following diseases: (Mumps, Measles, Diphtheria, Pertussis, Chickenpox, Tuberculosis), Please specify if any			
16	Viral Hepatitis			
17	Poliomyelitis (Infantile paralysis infection)			
18	Mental of Behavioral Problem, Please specify if any			
19	Any other Problem or disease not mentioned here, Please specify if any			

20	Is there a previous exposure to any accident?			
21	Is there any previous hospitalization? Please mention the cause if any			
22	Is there any previous exposure to surgery? Please mention the cause if any			
23	Is there any previous blood, antibodies or plasma transfusion?			
24	Was there a need to use any medical aid device? Please Was there a specify if any			

If the student suffer from one of the health problems mentioned or not mentioned above, please answer the following questions

Drugs or Treatments taken continuously

Drug Name: …… **Dosage: ……**

Emergency Drugs

Drug Name: ……. **Dosage: ……**

Specific Instructions of the treating doctor regarding Nutrition:

Specific Instructions of the treating doctor regarding exercise and physical activity

.....

Specific Instructions of the treating doctor to school nurse to be applied during the school day

.....

Family Health History

	Health Problem	Yes	No	Comments
1	Hypertension			
2	Diabetes			
3	Tuberculosis			
4	Mental disorder			
5	Stroke			
6	Others, specify			

Parent or Guardian approval and verification for the above mentioned information

Name of Parent or Legal Guardian:

Relationship:

Signature of the parent or legal Guardian:

Date:

Notes

The parent of legal guardian of the student should fill this form. He or she is responsible for the above-mentioned information.

Medical report about the health problem should be attached.

Parents and Legal Guardians are responsible for informing school nurse about any change that occur in health status of the student. They should provide the school nurse with the required reports needed to be added the student health file.

Please contact school nurse or doctor if there is any further queries

Kent Nursery
DUBAI

Medical & Immunization Record & Consent Declaration
CONFIDENTIAL

Has your child suffered from any of the following? If yes, please indicate dates in the Yes Box.

Illnesses/Conditions	Yes/Dates	NO	Illnesses/Conditions	Yes/Dates	NO
Dysentery			Congenital Heart Disease		
Infective Hepatitis			Diabetes Mellitus		
Rubella			Epilepsy / Seizures		
Scarlet Fever			Rheumatic Fever		
Whooping Cough			Thalassemia		
ADHD			Surgical Operations		
Nocturnal Enuresis			Frequent Gastric Problems		
Serious Accidents			Frequent Headaches		
Eczema			Other		
Bronchial Asthma					

History of: Blood Transfusion	Yes / No	
Hospitalisation	Yes / No	
Is your child taking medication at present?	Yes / No	

Child History:

Allergies	
Medication	
Treatment	

Please explain any Yes responses to the above in more detail, including treatment, dates and any medications taken on a regular basis, as a result. If you have any other concerns about your child, please mention them here.

_____

_____

_____

_____

Please note that if your child commences any new medication, treatment or changes their existing medication, the School Nurse must be informed.

PARENTAL CONSENT

Please note that all consents are valid for the duration of time that your child attends Kent Nursery. As the Parent / Guardian of _____ (print child's name), I give my consent to the following.

1: CONSENT FOR MEDICAL EXAMINATION

This service may be offered by Kent Nursery every Academic School Year; however, if you prefer to have your child examined by your own family GP you may do so at your convenience. The school will require a copy of the doctor's report to keep on file in your child's school health record.

We would also like to reassure parents that the safety and wellbeing of the children are of prime importance to us and that they are supervised at all times during medical examination by the School Nurse.

_____YES, I give consent for Medical Examination/BMI measurement in the school.

_____NO, I don't want my child to do Medical Examination/BMI Measurement in the school.

Name of the Parent: _____ Signature:_____

2: CONSENT FOR DENTAL EXAMINATION

The Nursery may conduct Dental screening

_____YES, I give consent for Dental Examination.

_____NO, I exclude my child from Dental Examination.

3: CONSENT FOR VISION EXAMINATION

The school may offer free vision checks

_____YES, I wish my child to be screened.

_____NO, I do not allow my child to be screened.

4: CONSENT FOR EMERGENCY TREATMENT

In the event that your child requires emergency treatment, you will be contacted and asked to collect your child from the school. If the school is unable to contact you, your child will be taken to a doctor/hospital for diagnosis and treatment. In the event of a serious incident, an ambulance will be called immediately. Efforts to contact you will continue.

I understand that my child will be taken to a doctor/hospital in the event of a medical emergency.

Emergency Telephone Numbers

Dubai Residence: _____ Name: _____

Dubai Mobile: _____ Signature: _____

The following are the First Aid medications available in the Nursery Clinic.
Please tick below the medicines that can be administered to your child when necessary.

Put a check mark	Name of the Medicine	Indications
	Panadol Tablet	Headaches & Body Pains
	Zrytec / Clarinase	Common Colds or Allergy
	Motilum Syrup / Tablet	Nausea & Vomiting
	Voltaren Gel / Reparil Gel	Muscular strains and aches
	Medijel Gel / Tee Gel	Mouth Sore / Mouse Ulcer
	Buscopan Tablet	Abdominal Pain / Period Pain
	Adol Syrup / Calpol	Fever & Pain
	Optrex Eye drops	Redness and itching of eyes
	Fenistel Gel	Insect bites and itching
	Fucidin Ointment	Minor and major wounds
	Flamazine cream / Mebo	Burns
	Zecuf Syrup / Amydramine Syrup	Cough
	Rennie Tablets	Gas Pain / Heart Burn
	Kaptin Syrup / Imodium	Diarrhoea
	Octrivin Nasal Drop	To clear blocked nose
	Prolyte powder	Dehydration
	Advil / Brufen	Severe Body Pains

Please do not give my child any of the above medicine: _____

Signature: _____ Date: _____

5: CONSENT FOR VACCINATION IN SCHOOL (as per the child's recommended Immunization schedule)

_____YES, I have no objection for vaccination in the school.

_____NO, I have objection for vaccination during the duration of my child in the school for the following reasons_____

_____

DUBAI HEALTH AUTHORITY IMMUNISATION SCHEDULE: (DHA Updated Year 2014)

AGE	**Name of the vaccine**
Birth	BCG & Hep. B(1st Dose)
2 Months	DPT, OPV, Hep B & Hib
4 Months	DPT, OPV, Hep B & Hib
6 Months	DPT, OPV, Hep B & Hib
12 Months / 1 Year	MMR - Chicken Pox 1st Dose
18 Months	DPT, OPV, Hib
5– 6 Years	PRESCHOOL BOOSTER:DPT, OPV & MMR (+Mantoux if no BCG yet) Chicken Pox (2nd Dose)
13-14 Years	DT, OPV (+ Mantoux if no BCG yet)
15 Years	TD - Tetanus Diphtheria

*Please arrange for your child to have the above-mentioned immunizations, if not already received. Please also provide a copy of the updated immunization record for the school clinic. If you have any questions, please contact us so that we may assist you. Please attach a photocopy of your child's immunization record or hand it over to the School Nurse

PLEASE ATTACH A PHOTOCOPY OF YOUR CHILD'S IMMUNIZATION RECORD ALONG WITH THIS FORM