GOVERNMENT OF DUBAI

DUBAI HEALTH AUTHORITY

Public Health Protection Department- School Health Section

Student Medical Form & General Consent

Student Photo

Dear Parent/ Guardian of the Student:

Please fill the following form accurately to ensure maintaining and monitoring your child's health and wellbeing during the school year

School Information
School Name: ..... Grade: ..... Section: .....

Student Information
Student Full Name: ..... Gender: .....
Date of Birth: ..... Nationality: .....
Parent or Legal Guardian Name: ..... Relationship: .....
Mobile Number (1): ..... Mobile Number (2): .....
E-Mail: ..... Emirate: .....
In case of Emergency and we are unable to reach the parent/guardian, the following person can be contacted:
Name: ..... Relationship: ..... Mobile Number: .....

Required Attachments			
Student's Emirates ID Copy	☐ Yes	☐ No	ID Number: .....
Student's Passport Copy	☐ Yes	☐ No	
Original Vaccination Card or Updated Copy	☐ Yes	☐ No	
Health Card Copy (if any)	☐ Yes	☐ No	Health Card Number: .....
Health Insurance Card Copy (if any)	☐ Yes	☐ No	

Student Medical History

	Health Problem	Yes	No	Comments
1	Does the student suffer from any allergy to medicine, food, dust, etc.? If yes, please specify in comments			
2	Does the student suffer from any Cardiovascular problem?			
3	Does the student suffer from Diabetes?			
4	Does the student suffer from Hypertension?			
5	Does the student suffer from Bronchial Asthma?			
6	Does the student suffer from any Renal Problem?			
7	Does the student suffer from Epilepsy or Convulsion seizures?			
8	Does the student suffer from Epistaxis?			
9	Does the student suffer from Hemolytic Anemia, type G6PD?			

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10	Does the student suffer from any Hereditary Blood Disease (e.g. Thalassemia, sickle cell anemia, Hemophilia)? If yes, please specify in comments			
11	Does the student suffer from any Skin Problem?			
12	Does the student suffer from any Eye problem (Myopia, Hyperopia…)? If yes, please specify in comments			
13	Does the student suffer from any Hearing problem?			
14	Dose the student use any medical aid device? If yes, please specify the device details in comments			
15	Did the student undergo any surgery in the past? If yes, please specify the details in comments			
16	Was the student ever hospitalized? If yes, please specify the reasons in comments			
17	Does the student have any health condition that could weaken the immune system such as Cancer (Blood cancer, Lymphoma), or an organ transplant? If yes, please specify in comments			
18	Did the student get any blood, antibodies or plasma transfusion in the past?			
19	Did the student suffer from any of the following diseases: (Mumps, Measles, Diphtheria, Pertussis, Chickenpox, Tuberculosis), If yes, please specify details in comments			
20	Did the student suffer from Viral Hepatitis?			
21	Did the student suffer from Poliomyelitis (Infantile paralysis infection)?			
22	Does the student suffer from any Mental or Behavioral Problem? If yes, please specify in comments			
23	Does the student suffer from any other Problem or disease not mentioned here? If yes, please specify in comments			

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

Medications or Treatments taken continuously

Medicine Name: ..... Dosage: .....

Emergency Medications

Medicine Name: ..... Dosage: .....

Any treating Doctor instructions on Student's nutrition

.....

Any treating Doctor instructions on Student's physical activity and exercise

.....

Any treating Doctor instructions for Student's School Doctor/Nurse to apply during the school day

.....

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Family Medical History

	Health Problem	Yes	No	Comments
1	Any Cardiovascular problem and Hypertension			
2	Diabetes			
3	Any Hereditary Blood Disease (e. g. Thalassemia, sickle cell anemia, Hemophilia)			
4	Any type of Cancer			
5	Any Immune System problem			
6	Any Mental Health problem			
7	Others, please specify in comments			

I agree for my child to have curative and/or preventive services that may include first aid, screening for height, weight, vision acuity, hearing test, dental checkup, Comprehensive Medical Examination, referral to emergency room when necessary, administer emergency medications when needed, and applying the Healthcare Management plan which is planned for based on the instructions of the treating doctor and parents.

Parent/ Guardian approval and verification for the above mentioned information

☐ **I certify that the above provided information are valid**

☐ **I agree for my child to be provided with the above mentioned health services according to the need**

☐ **I disagree for my child to be provided with the above mentioned health services (**In case of refusal, the above services will not to be offered except in emergency situations which require immediate intervention)

Parent /Guardian Name: ..... Relationship: .....

Parent/ Guardian Signature: ..... Date: .....

Notes

- **Please attach medical reports about the Student's health problem, if any**
- **It is the responsibility of the Student's Parent/ Guardian to inform the school clinic of any changes in the Student's health status and submit medical reports accordingly to update the Student's Medical Record at School.**

Please contact the School Doctor/Nurse if there are any queries

DUNECREST AMERICAN SCHOOL

Immunization Consent

Name of Student: _____

Date of Birth : _____

Grade Level : _____

Please tick ✓

☐ I give the consent for the immunization of my child

☐ I don't agree for immunization of my child

Reason: _____

_____

Parents/ Guardian Name: _____

Signature: _____

Date: _____

Phone number: _____

DUNECREST AMERICAN SCHOOL

Student Name:_____ **Grade:** _____

Dear Parent,

The following are the first aid medications available in the school clinic. Please check **(√)** the medicine that can be administered to your child when required.

DRUG	ACTION	YES	NO
Panadol Advance syrup/tablet	Pain/ Fever		
Panadol Cold and Flu/ All in One	Cold/ Headache		
Brufen syrup/tablet	Severe pain/ high fever		
Buscopan tablet / Scopinal Syrup	Stomach pain/ cramps		
Motillium syrup/tablet	Stomach pain/ Indigestion /Nausea		
Premosan syrup/tablet	Anti-emetic/ nausea and vomiting		
ENO fruit Salt	For indigestion/ Stomach ache		
Prolyte (Oral Rehydration Solution)	Dizziness/ Dehydration		
Moxal tablet	Heart burn/ Hyperacidity		
Zyrtec syrup/tablet	Anti-Allergy		
Fenistil tablet	Anti-Allergy		
Prospan syrup	Cough		
Sedofan syrup	Cold		
Ventolin syrup	Cough/ Asthma attack		
Chloraseptic spray	Sore throat		
Strepsils	Sore throat		
Toothache gel	Toothache/ gum pain		
Medigel	Mouth ulcer/ Painful gums		
Fucidin ointment	Antibiotic for wounds		
Fenistil gel	Itchy rashes/ Allergy		
Afterbite gel/cream	Insect bites		
Voltaren gel	Muscle pain /swelling		
Reparil Gel	Bruise /swelling		
Deep Heat cream	Muscle pain		
Flammazine	Burns		
Eucerin/ Oilatum Cream	Eczema/ dry skin		

Medicine Allergies: _____

_____

Signature of Parent: _____