

STUDENT'S HEALTH INFORMATION – PART 1

Personal Data

Name			
Date of Birth		Class and Section	
Nationality		Sex	
Name and Location of Previous School			

Contact Information

Father's Name		Mobile No.	
Mother's Name		Mobile No.	
Address		Home No.	

Sibling Information

Name	Class and Section

Medical Information

Is there any significant family history of illness?	
Please indicate if your child has any ALLERGY	
Wear eye glasses?	
Has hearing difficulties?	
Take medication on a regular basis?	
Has any chronic illness?	
Has any physical disabilities?	

STUDENT'S HEALTH INFORMATION – PART 2

Consent for Medication and Transfer to Hospital

In the event that your child gets sick whilst in school and we are not able to contact you, we request your consent for us to give appropriate care. *(Please encircle your preference)*

- I do I don't Allow the School to give Paracetamol, Brufen, Lozenges and Antacid.
- I do I don't Allow the School to transfer my child to Hospital in case he/she needs urgent medical attention.
- I do I don't Give consent for the medical examination of my child in School (measurement, height, weight, screening of vision, examination of ears, throat, heart, lungs, abdomen and in boys, check for the normal genital development). If you do not agree, you must do it with your own doctor and provide us a medical report.

PART 3

As required by Dubai Health Authority, please fill out the attached **Consent for Immunization** and **child's illness**, and provide a copy of your child's **vaccination record**. Be assured that all information will be treated with confidentiality. Please submit the **original vaccination record** of your child if you have given consent for immunization. ***Vaccinations will not be given until the original record has been submitted.***

NAME & SIGNATURE OF PARENT _____

DATE _____

PRIMARY HEALTH CARE
SCHOOL HEALTH SERVICES
P.O.BOX: 1899 - DUBAIالرعاية الأولية للصحة
خدمات الصحة المدرسية
ص.ب: 1899 - دبي

CONSENT FOR IMMUNIZATION

موافقة على اجراء التطعيمات

Name of the child: _____ اسم الطفل
Date of Birth: _____ تاريخ الميلاد
Name of the School: _____ اسم المدرسة
Class/Grade: _____ الفصل/الصف

Please tick (✓)

 I give the consent for the immunization of my child. اصرح بان تعطى التطعيمات اللازمة لابني/ لابنتي.
 I do not agree for immunization of my child. لا اوافق باعطاء التطعيمات لابني/ لابنتي.
Name and Signature: _____ اسم و توقيع:

PARENT/ GUARDIAN

الأهل/ الوصي

P.O.BOX: _____ صندوق البريد:

Telephone Number: _____ رقم الهاتف:

Dear Parents

حضرة الأهل الكرام

Please provide the following information update
your child School Health Record and send his/her
ORIGINAL IMMUNIZATION CARDنود الطلب منكم بتزويدنا بالمعلومات التالية
لاضافتها الى الملف الصحي لابنكم / لابنتكم
و ارسال سجل التحصينات الأصلي

CHILD'S HISTORY OF ILLNESS:

سجل الأمراض ما قبل الدخول الى المدرسة:

Please tick (✓) appropriately

الرجاء وضع علامة (✓) في المكان المناسب

If yes, specify Month/Year of illness.

اذا كان الرد بنعم يرجى تحديد تاريخ حدوث الإصابة

INFECTION DISEASES	YES	NO
Diphtheria		
Dysentery		
Infective Hepatitis		
Measles		
Mumps		
Poliomyelitis		
Rubella		
Scarlet Fever		
Tuberculosis		
Whooping Cough		
Chicken Pox		

NON-INFECTIOUS DISEASES	YES	NO
Accidents		
Allergies		
Bronchial Asthma		
Congenital Heart Disease		
Diabetes Mellitus		
Epilepsy		
G6PD (Glucose6-phosphate dehydrogenates deficiency)		
Rheumatic Fever		
Surgical Operations		
Thalassaemia		

If yes, write the year of illness

History of: Blood Transfusion No Yes, Frequency: _____
Hospitalization No Yes, Reason: _____ Date: _____

Family History:

 Diabetes - Hypertension - Mental Disorders - Stroke - Tuberculosis - Other, Specify: _____

Licensed School Nurse

DOH/PHC/SHS - 01

FORM A