RENAISSANCE SCHOOL

Medical Form

Confidential

Student Information

Child's Name_____ Date of Birth_____

Nationality_____Gender_____

Father's Name_____Mother's Name_____

Address_____

Contact Numbers:

Father's mobile_____ Mother's mobile_____

Residence_____ Office_____

Student's Medical History

Please tick (√) appropriately, if Yes, specify Month/Year of illness

INFECTIOUS DISEASES	NO	YES	DETAILS	DISEASE/CONDTION	NO	YES	DETAILS
Diptheria				**Accidents**			
Dysentery				**Allergies**			
Infective Hepatitis				**Bronchial Asthma**			
Measles				**Congenital heart Disease**			
Mumps				**Diabetes mellitus**			
Poliomyelitis				**Epilepsy**			
Rubella				**G6PD**			
Scarlet Fever				**Rheumatic Fever**			
Tuberculosis				**Surgical Operation**			
Whooping Cough				**Thalassemia**			
Chicken Pox				**Others**			

History of : Blood Transfusion □ Yes □ No Details_____

Hospitalization □ Yes □ No Details_____

Family History:

Heart Disease/Diabetes/Hypertension/Mental Disorder/Stroke/Tuberculosis. Others, specify_____

Currently using □Braces □Crutches □Eyeglass/Contact lenses

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Accident/Emergency Consent

In the event of an emergency or accident where the student needs URGENT medical attention. It is the policy of the school to take the student to the nearest emergency department. Every effort will be made to contact you prior to transfer. Please sign below.

Guardian/Parent Name _____

Signature _____

Date _____

Emergency Contact _____

Health Insurance Company Name _____

Child's Health Insurance Policy No. _____

I have enclosed a copy of the health insurance card □ YES □ NO

Medical Examination Consent

According to the Dubai Health Authority Regulations, every student requires to attend a medical examination.

The examination is carried out by the female school doctor and include measurement of height and weight, screening of vision and examination of ears, throat, heart, lungs and abdomen.

If you prefer to have your child examined by your family doctor you may do so at your convenience. **The school requires a copy of medical report to keep on your child's school health file.**

Please tick below and we will contact you when your child is scheduled for examination.

I consent to my child having a medical examination at school □YES □NO

I would like to be present during the examination □ YES □NO

Guardian/Parent's Name _____

Signature _____

Date _____

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Medication Administration Consent

Please tick(√) the appropriate box, and sign your name to give consent for the administration of these medications.

- □ **I do not allow my child to receive medications from the school clinic.**
- □ **I allow my child to receive medications from the school clinic.**

Please tick (√) the medicine you want your child to receive in the clinic.

Name of medicine	Indication or use of medicine
○ **Ibuprofen syrup/tablets**	**Pain, swelling**
○ **Paracetamol syrup/tablets**	**Head ache, fever, pain**
○ **Claritine syrup/tablet**	**Allergy**
○ **Maalox suspension/rennie tabs**	**Heart burn and acid indigestion**
○ **Fenistil/bite cream/gel**	**Insect bites**
○ **Arnica gel**	**Bruise, swelling**
○ **Betadine**	**Wound cleansing**
○ **Fucidin ointment**	**Antibiotic cream for wounds**
○ **Burn gel/spray/cream**	**Burns**
○ **Deep heat spray**	**Muscle pain**
○ **Junior strepsils**	**Sore throat**

Guardian/Parent's Name _____

Signature _____

Date _____

Medication Policy

Medication prescribed by your family doctor that needs to be given during school day should be administered by the school nurse. The **parent** is required to hand in the medication with the written prescription from the doctor and sign a specific consent form available at the clinic.

If your child has asthma, allergies or other conditions requiring the use of inhalers, nebulizers, Epipen or other medication we require such medication to be kept in the clinic that can be given in an emergency situation.

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Medial Form **Confidential**

Sickness Exclusion Policy

if the student has a **fever, diarrhea or vomiting** they are **not allowed** to attend school and may only return after **24 to 48 hours** from the last episode of diarrhea or vomiting, fever and fever-reducing medication. If the students develop the above symptoms while in school, parents will be contacted and required to collect the student immediately.

In cases of communicable and infectious diseases or conditions, the school clinic should be notified as per Dubai Health Authority Regulation and the parent must present a medical certificate that the child is fit to be in school.

Consent for Immunization

The Dubai Health Authority (DHA) requests that the school keep an up to date register of each child's immunization history. **The immunization record should be translated to English if it is in any language.**

In line with the Dubai Health Authority (DHA), please note that no child can be vaccinated in school under the age of 6years. Immunizations must be completed by parents up to the age of 6 years.

If you do wish your child to be vaccinated in school after the age of 6 years, this will be conducted by nurses from the Dubai of Health Authority (DHA).

Please tick (√) as appropriate

□ **I give consent for the immunization of my child at school**

Guardian/Parent's Name _____

Signature _____

Date _____

If you do not wish your child to be immunized in school, it is compulsory to complete the section below and refusal form from the Dubai Health Authority.

□ **I do not give consent for the immunization of my child at school**

Reason_____

Guardian/Parent's Name _____

Signature _____

Date _____

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Certificate of Immunization

The Dubai Health Authority requires Renaissance School maintains current information of each student's immunization history, therefore, it is important that this form is completed in full

I confirm that the attached is a true copy of my child's immunization record. I will inform the school of any further update of immunizations/boosters my child received.

Guardian/Parent's Name _____

Signature _____

Date _____

DOHMS Records

For New Students Only

If your child previously attended another school in Dubai; please tick (√) the appropriate box below.

Name of previous school in Dubai:_____

- □ We have the School Health Record in our possession and will submit it to the clinic.
- □ As far as we are aware the school still has the file.

Received by:

Name of School Nurse _____

Date Received _____

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Student Name _____

Class/Year _____