

## Student Medical Form

Photo

### 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 comments cell. Accuracy is needed for us to be able to follow their health status.

Best wishes for good health and wellness

<b>School Information</b>			
School Name: .....Grade: .....Class: .....			
<b>Student Information</b>			
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: .....			

<b>Required Attachments</b>			
Student Emirates ID	Yes	No	ID Number: .....
Student Passport Copy	Yes	No	
Original Vaccination Card	Yes	No	
Health Card Number (if any)	Yes	No	Health Card Number: .....
Health Insurance Card (if any)	Yes	No	Health Insurance Card Number: .....

<b>Medical History of the student</b>				
Is there any health problem, out of the following? If the answer is yes, please state the problem type and date in comments cell				
	<b>Health Problem</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
1	Any allergy to drug, food, dust .....			
2	Cardiovascular problem			
3	Diabetes			
4	Hypertension			
5	Asthma			
6	Renal Problem			
7	Epilepsy seizures or Convulsion seizures			

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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 or 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 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**

.....

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<b>Specific Instructions of the treating doctor to school nurse to be applied during the school day</b> .....				
<b>Family Health History</b>				
	<b>Health Problem</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
1	Hypertension			
2	Diabetes			
3	Tuberculosis			
4	Mental disorder			
5	Stroke			
6	Others, specify			
<b>Parent or Guardian approval and verification for the above mentioned information</b>				
Name of Parent or Legal Guardian: .....				
Relationship: .....				
Signature of the parent or legal Guardian: .....				
Date: .....				
<b>Notes</b>				
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

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## CONSENT FOR IMMUNIZATION

Child Name: -----  
 Date of Birth: -----  
 School Name: -----  
 Class/Grade: -----

Please Tick (√)

- I give the consent for the immunization of my child  
 I don't agree for immunization of my child.

Name & Signature: -----  
Parents/ Guardian

P.O.Box:-----  
 Telephone Number: -----

**Dear Parents**

Please provide the following information to update your child school health record and send his/her ORIGINAL IMMUNIZATION CARD

**Child History of illness:**

Please tick (√) appropriately, if yes, Specify Month/Year of illness

Infectious Disease	YES	NO	Non-Infectious Disease	YES	NO
Diphtheria			Accidents		
Dysentery			Allergies		
Infective Hepatitis			Bronchial Asthma		
Measles			Congenital Heart Disease		
Mumps			Diabetes Mellitus		
Poliomyelitis			Epilepsy		
Rubella			G6PD (Glucose6-Phospate Dehydrogenase deficiency)		
Scarlet Fever			Rheumatic Fever		
Tuberculosis			Surgical Operation		
Whooping Cough			Thalassemia		
Chicken Pox					

If yes, write the year of illness

History of:

Blood Transfusion      No      Yes,      Frequency: -----

Hospitalization      No      Yes,      Reason: -----Date: -----

family History: Diabetes- Hypertension- Mental Disorder- Stroke- Tuberculosis-

Other, Specify-----

Licensed School Nurse Signature: -----

## Administration of Medication

In the event that your child requires first aid medication and I am unable to contact you, please tick below the medications that can be administered to your child when necessary.

Medication	Reason for administering medication
Panadol Elixir*	Headache, fever and body aches.
Panadol Baby & Infant suspension*	Headache, fever and body aches.
Brufen/ Nurofen*	Headache, high grade fever
Prospan Syrup (paediatric)*	Cough
Zyrtec Syrup*	Insect bites and itching
Scopinal Syrup*	Abdominal pain
Adol / Voltaren rectal suppository*	High grade fever
Optrex Eye Drops	Redness and itching
Otrivin Nasal Drops	To clear blocked nose

*\*You will be contacted prior to administration of these medications*

### CONSENT FOR ADMINISTRATION OF PARACETAMOL

In the event that your child develops a fever or pain, and I am unable to contact you Panadol or Adol will be administered.

Name of Child \_\_\_\_\_ (please print)

Signature of parent \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT FOR MEDICAL EXAMINATION

According to the Department of School Health guidelines, children require a medical examination at various key stages in their lives (new student, Year 1, Year 5, Year 9 and student leaving).

This service is currently offered to you by Star International. 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.

Medical examination is carried out by the school doctor.

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

### **I consent to my child having a medical examination at school**

Name of child \_\_\_\_\_ (please print)

Signature of parent \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT FOR EMERGENCY TREATMENT

In case of serious accident or emergency, the school requires permission to administer emergency first aid and arrange transport and treatment to a hospital, Every attempt will be made to contact you.

### **PLEASE ENSURE THE SCHOOL HAS YOUR UP TO DATE CONTACT DETAILS**

I understand that my child will be taken to a doctor / hospital in the event of a medical emergency. I give consent to Star International School to administer first aid and arrange transport to hospital and emergency treatment as considered necessary.

Name of Child \_\_\_\_\_(please print)

Signature of parent \_\_\_\_\_ Date \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

**Please note that all consents are valid for the duration of the time that your child attends Star International.**

## STAR INTERNATIONAL SCHOOL INFECTION CONTROL POLICY

In order to minimize the spread of infections in the school, the following regulations apply.

**Please DO NOT send your child to school if they have:**

- **A fever. Must be free from fever without the aid of medication for 24 hours.**

- A skin rash with fever.
- Vomiting (not to return to school for 24 hours after the last vomiting episode).
- A heavy nasal discharge.
- A recurrent sore throat with fever.
- Red, watery and painful eyes. Especially if there is a yellow discharge.

If you are in doubt regarding your child’s condition please visit the school nurse before the start of the school day for confirmation that it is “safe” for your child to be in school.

If your child has an infected sore or wound it must be covered by a well-sealed dressing or plaster.

If your child is assessed by the school medical team and thought to be possible source of infection to other students and staff, you will be contacted to take them out of school immediately.

**HEAD LICE** remains a constant problem for communities in general. Control of head lice depends on prompt diagnosis and effective treatment. Your help in inspecting your child at least weekly throughout the school year for the presence of head lice would be greatly appreciated.

If you suspect your child is infested with head lice please notify the School Nurse and only send to school if proper treatment has been initiated.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

### **MEDICAL INFORMATION**

**MEDICAL FORMS**, when your child starts at Star International School, you will be required to complete several medical forms. Please return them promptly with all medical information provided. It is utmost importance that the school is made aware of any condition your child has and any medication they are receiving. This will affect how they are treated in case of an emergency.

**MEDICATIONS**, students are not permitted to carry medicine with them under any circumstances. If your child needs medication at school, please hand it to the school nurse where it will be stored safely in the clinic. You may also provide the school nurses medicine your child may need at school for an existing condition such as an inhaler for asthma, insulin for diabetes or an EpiPen for allergies. Medicine will not be returned to a student under any circumstances; it must be collected by an adult, either the parent/guardian or the teacher.

**SNACK BOXES**, to support your child’s concentration at school, please encourage them to have nutritious food in their snack boxes. Sweets, cakes and sweet biscuits are strongly discouraged. Fizzy drinks and chewing gum are not allowed. Treats day is only during Thursday.

**PLEASE NOTE:** Due to the fact that there are students with nut allergies, nuts and food containing nuts are strictly forbidden! A peanut allergy can result in a potentially fatal anaphylactic reaction. The parents of these students trust you to ensure your child does not bring nuts to school.