GEMS WELLINGTON
INTERNATIONAL SCHOOL

مدرسة جيمس ولينجتون
انترناشونال

Medical and Immunization Record with Consent Declaration

Confidential

EDUCATION

GEMS Wellington International School
PO Box 37486, Dubai, United Arab Emirates
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INTERNATIONAL SCHOOL انترناشونال

MEDICAL & IMMUNISATION RECORD WITH CONSENT DECLARATION

(Confidential)

Dear Parents,

It is required by the Dubai Health Authority and by the school that all students must have their own school health records maintained in individual files within the school clinic. We are updating our health records and making fresh ones for students who are new in UAE. **Please complete all the pages of the attached Medical Form** as this will enable the school medical team to have a better understanding of your child's general health condition. Please notify the school if your child is suffering from any **chronic medical condition or having any specific treatment**. If there is a change in his /her medication or a new medicine started for a recently diagnosed illness, please inform the school medical staff as early as possible.

Dubai Health authority requires that the school maintains current information of each child's immunization history. Kindly provide a **true photocopy of the original vaccination card** along with this form. If the vaccination card is in your regional language, you are will have to provide a **translated copy in English** which is properly attested by your private doctor. Each time your child takes a vaccine outside school, kindly inform the school clinic ASAP so that the data base is updated with DHA.

Please sign the medical form in pen (not in pencil) and provide a **recent passport size photograph** of your child. If your child has been in another school in Dubai prior to this school, you must write the name of the school on the attached letter.

Please return the form to the school clinic in two days. If you consider any other information necessary for your child's medical file, write on a separate paper and attach.

Kindly note that all consents are valid for the duration of time that your child stays in GEMS Wellington International School.

Thank you for your attention.

School Medical Team,

GEMS Wellington International School

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حكومة دبي
GOVERNMENT OF DUBAI

هيئة الصحة بدبي
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?			

Public Health Protection Department- School Health Section

Student Medical Form & General Consent

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 ....

GOVERNMENT OF DUBAI

هـيئـــة الصحـــة بدبـــي
DUBAI HEALTH AUTHORITY

Public Health Protection Department- School Health Section

Student Medical Form & General Consent

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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

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In the event that your child develops fever, pain, allergy or any other symptom or if he/she has injured himself/herself, it may be necessary to administer some medication. This is to authorise the School Doctor/Nurse to administer the appropriate medicines for various situations. **The following are the First Aid Medications available in the sick bay.** Please tick **√** the medicines below that can be administered to your child when necessary in school.

√	S.No.	Name of the medicine	Indication
	1.	Claritin Tab/ Syrup Zyrtec	Common Cold or Allergy
	2.	Prospan Syrup	Cough
	3.	Strepsils / Vicks Lozenges	Sore throat
	4.	Panadol cold and flu tablet	Common cold and headache (only above 12 years of age)
	5	Panadol Tab or Adol Syrup	Headache, fever or body ache
	6	Adol Suppository	High fever (small children only)
	7	Brufen Tab/ Syrup	Pain/ Inflammation /swelling
	8	Buscopan Tab/ Scopinal Syrup	Abdominal pain/ cramps
	9	Motilium Tab/ Syrup Dompy	Nausea and Vomiting
	10	ORS powder with water	Dehydration
	11	Rennie Chewable Tab	Dyspepsia & Heart Burn/gas pain
	12	Voltaren Gel/ Reparil gel	Muscular Sprains and aches
	13	Fucidin ointment	Minor and major wounds, skin infections etc
	14	Fenistil Gel	Insect bites and itching
	15	Flamazine cream/ Mebo	Burns
	16	Medijel Gel	Mouth sores/ mouth ulcers
	17	Bepanthen cream	Minor skin injuries, grazes (abrasions) etc.
	18	Optrex Eye drops	Eye irritation, mild redness
	19	Otrivin Nasal Drops	Blocked nose
	20	Calamine lotion	Sun burns, itchy or irritated skin

OR

☐ **Please do not give my child any of the above medications**

Comments:____

____

Name of the Parent: ____

Signature: ____________________________________ Date: _________________________________

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INFECTION CONTROL POLICY

In order to reduce and minimize the spread of illnesses in the school, the following regulations shall apply.

1. Please do not send your child to school if they have:
    - A fever (Not to return to school for 24 hours after the last fever episode)
    - A skin rash (until the rash clears the contagious stage)
    - Persistent vomiting (not to return to school for 24 hours after the last vomiting episode)
    - Persistent diarrhea (not to return to school for 24 hours after the last diarrhea episode)
    - A persistent cough or sore throat
    - Heavy nasal discharge
    - Red, watery, sticky with discharge and painful eyes
    - Head lice
2. If he/she has an infected sore or wound, it must be covered by a well-sealed dressing or plaster.

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

4. Please make sure that a proper medical treatment is taken and inform the school health office if your child is being treated for a medical condition.

5. Kindly make sure that your child practices hand hygiene, maintains short nails, clean clothes and clean hair etc.

6. Anyone infested with head lice will not be allowed in school until the hair is thoroughly treated and is free from lice. Every week please check your child for head lice or nits and if he/she is infested, start the treatment at home and report the same to the school nurse. It will be kept confidential.

I have read and understood the above infection control policy.

Name of the parent: ____

Signature: ________________________________ Date: _______________________________