# 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

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| School Information |
| School Name: ………………………………………………………………………………………………….. Grade: ……………………….. Class: ……………………………………….. |
| **Student Information** |
| 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: …......................................... |

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| **Required Attachments** |
| Student Emirates ID | Yes | No | ID Number: ……………………………………………………………………………………. |
| Student Passport Copy | Yes | No |  |
| Original Vaccination Card or updated colored copy(authorized) | Yes | No |  |
| Health Card Number (if any) | Yes | No | Health Card Number: ………………………………………………………………….. |
| Health Insurance Card (if any) | Yes | No | Health Insurance Card Number: ………………………………………………… |

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| **Medical History of the student** |
| **Is there any health problem, out of the following? If the answer is yes, please state the problem type and date in comments cell** |
| **Health Problem** | **Yes** | **No** | **Comments** |
| 1 | Any allergy to drug, food, dust ….. |  |  |  |
| 2 | Cardiovascular problem |  |  |  |
| 3 | Diabetes |  |  |  |
| 4 | Hypertension |  |  |  |
| 5 | Asthma |  |  |  |
| 6 | Renal Problem |  |  |  |
| ID | Issue# | Issue Date | Effective Date | Revision Date | Page# |
| CP\_6.2.14\_F01 | 01 | Jan 01, 2019 | Mar 01, 2019 | Jan 01, 2021 | 1/1 |

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| --- | --- | --- | --- | --- |
| 7 | Epilepsy seizures or Convulsion seizures |  |  |  |
| 8 | Epistaxis |  |  |  |
| 9 | Hemolytic Anemia, type G6PD |  |  |  |
| 10 | Hereditary Blood Disease (e. g. Thalassemia, sickle cellanemia, 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 of Behavioral Problem, Please specify if any |  |  |  |
| 19 | Any other Problem or disease not mentioned here, Pleasespecify if any |  |  |  |
|  |  |  |  |  |
| 20 | Is there a previous exposure to any accident? |  |  |  |
| 21 | Is there any previous hospitalization? Please mention thecause if any |  |  |  |
| 22 | Is there any previous exposure to surgery? Please mentionthe cause if any |  |  |  |
| 23 | Is there anytransfusion? | previous | blood, antibodies | or | plasma |  |  |  |
| 24 | Was there a need to use any medical aid device? Pleasespecify 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****…………………………………………………………………………………………………………………………………………………………………………………………………………..** |

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