Al-Mizhar American Academy

Medical and Immunisation Record and Consent Declaration

CONFIDENTIAL

Please attach a passport-size photograph here.

Child's Name: _____

Please complete this form and return it prior to your child starting at the American Academy in Al-Mizhar (AAM).

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COMPULSORY ON ACCEPTANCE

The information provided will be treated as confidential by all staff. If you have any queries please feel free to contact the nurse, who will be happy to answer any questions.

Name of Child: _____ Class: _____

Nationality: _____ Date of Birth: _____ Gender: M ☐ F ☐

Address: _____

Father's Name: _____ Father's Mobile: _____

Mother's Name: _____ Mother's Mobile: _____

Residence Tel No.: _____ Office Tel No.: _____

Has your child had any of the following? If yes, please indicate dates in the 'Yes' box.

ILLNESSES	*Yes*	*Details/Year*
Diphtheria		
Dysentry		
Infective Hepatitis		
Measles		
Mumps		
Pollomyelitis		
Rubella		
Scarlet Fever		
Tuberculosis		
Whooping Cough		
Chicken Pox		
Other		

CONDITIONS	*Yes*	*Details/Year*	*Treatment*	
Accidents				
Allergies				
Bronchial Asthma				
Congenital Heart Disease				
Diabetes Mellitus				
Epilepsy				
G6PD				
Rheumatic Fever				
Surgical Operation				
Thalasaemia				
Immunocompromised				
Other				

History of: **Blood Transfusion** **No** ☐ **Yes** ☐ Details: _____

Hospitalisation **No** ☐ **Yes** ☐ Reason: _____

Family History:

Diabetes ☐ **Hypertension** ☐ **Mental Disorders** ☐ **Stroke** ☐ **Tuberculosis** ☐ Other, please specify:

_____

Currently using:

Braces ☐ **Crutches** ☐ **Eyeglasses** ☐ **Contactlenses** ☐

Please indicate below if your child us having any allergies or any medical conditions:

Allergy: _____

Medical Condition: _____

Medication Administration Consent

As children sometimes become ill at school with headaches, colds, hay-fever, menstrual cramps, toothache etc., we have a supply of non-prescription medicines available to relieve such symptoms. Please tick the appropriate box, write your name and sign below to give consent for the administration of these medications when deemed appropriate by the school nurse.

I would like my child to receive over-the-counter medication for fever, pain and minor ailments if needed: Yes ☐ No ☐

Guardian/Parent Name (please print): _____

Signature: _____ Date: _____

Accident/Emergency Consent

In the event of an emergency or accident where your child needs URGENT medical attention, it is the policy of the school to take the child to the nearest accident and emergency department. Every effort will be made to contact you prior to transfer. If however we are unable to reach you, we require a consent to allow us to transfer your child to the accident and emergency department of the nearest facility. Please sign here:

Guardian/Parent Name (please print):_____

Signature: _____ Date: _____

Preferred Hospital:_____

Prescriptions Medications

Please complete below with regards to any prescription medication your child is currently taking:

Medication Name:_____ Medication Dosage:_____

Diagnosis requiring medication:_____

Vaccination Record

Please include a copy of the original vaccination report (please tick appropriate box).

I hav enclosed a copy of the vaccination report: Yes☐ No☐

Guardian/Parent Name (please print):_____

Signature: _____ Date: _____

Consent for Medical Examination

It is a requirement of the Dubai Department of Health and Medical Services that all children should undergo medical examination when they join the school, in Year 1, 5 and 9 and when they leave the school. Our school doctor will carry out the medical examination. This includes measurement of height and weight, screening of vision, examination of the ears, throat, heart, lungs and abdomen.

If you do no consent to the medical being carried out in the school, you must do it privately with your own doctorand provide us with the medical report for your child's file.

☐ I consent for the medical examination of my child in school.

☐ I do not consent for the medical examination of my child in school.

DOHMS Records

Please complete below if your child previously attended another school in Dubai:

Name of previous school in Dubai:_____

We are in possession of the school health record and will bring it into the nurse's clinic: ☐

As far as we are aware the previous school still has the school health record: ☐

Dear Parents,

The following medicines will be administered as needed ONLY if initialed by parents/guardians.

_____	**Panadol Advance**	Headache/ Fever/Body pain
_____	**Panadol Cold and Flu**	For Cold and Flu
_____	**Panadol Elixir Syrup (4-12 yrs)**	Fever/Body Pain/Headache
_____	**Brufen Tablet, 400mg (12 yrs above)**	Headache and Pain
_____	**Brufen Syrup**	Headache and Pain
_____	**Buscopan Tablet 10 mg (from 12 yrs)**	Abdominal Pain
_____	**Buscopan Syrup**	Abdominal Pain
_____	**Fluket Syrup (6-12 yrs)**	For Cold, Flu and Hay Fever
_____	**Melrosum Syrup (3-12 yrs)**	Cough
_____	**Zyrtec Syrup**	Allergic Reactions
_____	**Fenistil Syrup**	Allergic Reactions
_____	**Gaviscon Syrup (6-12 yrs)**	Abdominal Pain/Hyperactivity
_____	**Kaptin Syrup**	Diarrhea
_____	**Imodium Tablet**	Diarrhea
_____	**Maalox Tablet (6-12 yrs)**	Pain Abdomen and Hyperacidity
_____	**Strepsils Lozenges (from 12 yrs)**	Sore Throat
_____	**Fucidine Cream Antibiotic**	Cuts and Wounds/Skin Infection
_____	**Mebo Cream**	Wound, Burn, and Ulcer
_____	**Calamine Lotion**	Itchiness/Skin Irritation
_____	**Reparil Gel (Application)**	Muscle Pain/Contusion Injury
_____	**Fenistil Gel**	Insect Bites/Allergic Reactions

_____ I ***do not*** wish my child to receive any medicines at school.

_____ I ***authorize*** the school nurse to administer the non-prescription medication that I have initialed.

All medication not initialed by parent/guardian will NOT be administered to your child.

Required Parent/Guardian Consent

This medication consent form is correct as far as I know. I understand that both forms must be filled out completely in order for my child to receive treatment at our school clinic.

I understand that in case of an emergency, every effort will be made to contact a parent/guardian prior to treatment.

If a parent/guardian cannot be reached, however and the situation requires emergency attention, I hereby authorize the school nurse to obtain emergency treatment for my child as deemed necessary.

Name of Child _____ DOB _____ Class _____

Allergies _____

Medical Condition and Other Information _____

Phone numbers where you can be reached during the day _____

Parent/Guardian Name (PRINT) _____ **Signature** _____ **Date** _____

Dear Parents,

This letter is to inform you that many students at AAM have a severe peanuts/nuts food allergy. Any exposure to peanuts/nuts may cause a life threatening allergic reaction that will require emergency medical treatment.

It is very important that there is strict avoidance to bring any food items to school that contain those products to prevent a life-threatening allergic reaction.
If you child has eaten peanuts/nuts before coming to school, please make sure that your child's hands and face have been thoroughly washed before entering AAM.

We are asking you to help us to provide all our students at AAM with a safe school environment.

Thank you for your support and cooperation. Please complete below and return this form to the school nurse at AAM, who will be happy to answer any questions you may have.

Parents/Guardians

I have read and understood that AAM is a peanut/nut free school and that any products/food items containing peanuts/nuts are not allowed at AAM.

Child's Name _____

Parents' Signature _____

Date _____