حكومة دبي
GOVERNMENT OF DUBAI

هيئة الصحة بدبي
DUBAI HEALTH AUTHORITY

PRIMARY HEALTH CARE

SCHOOL HEALTH SERVICES

SCHOOL HEALTH RECORD

DEAR PARENTS:

PLEASE PROVIDE THE FOLLOWING INFORMATION TO UPDATE YOUR CHILD SCHOOL HEALTH RECORD AND SEND HIS/HER **ORIGINAL IMMUNIZATION CARD OR UPDATED COPY** ACCORDING TO HEALTH AUTHORITY OF DUBAI VACCINATION POLICY.		
NAME OF THE STUDENT-		EMIRATES ID -
NATIONALITY-	SEX: -	DATE OF BIRTH -
FATHER NAME:		CONTACT NO -
MOTHER NAME:		CONTACT NO: -
EMERGENCY NO: 1:		EMERGENCY NO:2: -
E-MAIL ID:		

SIGNIFICANT INFORMATION:

ALLERGY: --------

(Please specify)

MEDICAL CONDITION:

(Please provide further details and indicate clearly whether this condition will, in your child's ability to participate in any aspect of school life, eg. Regular classes, Sports, Field trips after school activities etc).

SNO	NAME OF THE PREVIOUS SCHOOL	YEAR	EMIRATE

SCHOOL HEALTH POLICY

POLICY ON MEDICATION

Medication will not be dispensed without written permission. If your child needs to take any medication during school hours, please ensure that this medication is stored in the School Clinic, with the nurse, and that it includes exact directions on administering the medicine including amount and frequency.

MEDICAL TREATMENT - PARACETAMOL

I consent / do not consent to my child being given Paracetamol, should be it be considered necessary by the school doctor or nurse.

If your child is unable to take this medication, please contact the school doctor or school nurse to discuss the use of an alternative medication.

The medical staff will contact you if there are any concerns.

CONSENT FOR EMERGENCY TREATMENT

In the event that my child requires emergency treatment, I will be contacted and asked to collect my child from the school.

If the school is unable to contact me, my child will be taken to a doctor or hospital for diagnosis and treatment. Efforts to contact me will continue.

SCHOOL 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

Fever, Skin Rash, Vomiting (not to return to school for 24 hours after the last vomiting episode), Diarrhea (not to return to school for 24 hours after the lat Diarrhea episode), Persistent cough (Heavy nasal discharge) Red watery and painful eyes.

2. An infected sore or wound must be covered by a well – sealed dressing or plaster.
3. If your child is assessed by the school Doctor and /or School Nurse, and deemed to be a possible source of infection to other students, you will be contracted to take the child home immediately.

Please inform the school if your child has been treated for a medical condition.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Name of Student : ..... Grade : ..... Date : .....

Emergency Contact NO./ Name of the Guardian : ..... Signature : .....

.....

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SCHOOL HEALTH FORMS

CONSENT FOR IMMUNIZATION AT ADMISSION

Child Name: ----------

Date of Birth: ----------

School Name: ----------

Class/Grade: ----------

Please Tick (¥)

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

Signature of Parents/ Guardian: ----------

Name of Parents/ Guardian: ----------

Telephone Number: ----------

Child History of illness:

Please tick appropriately, if Yes, specify Month/ year of illness

INFECTIOUS DISEASES	YES	NO	NONINFECTIOUS DISEASE	YES	NO
Diphtheria			Accidents		
Dysentery			Allergies(please specify)		
Infective Hepatitis			Bronchial Asthma		
Measles			Congenital Heart Diseases		
Poliomyelitis			Diabetes Mellitus		
Rubella			Epilepsy		
Scarlet Fever			G6PD(Glucose6-Phosphate Dehydrogenises deficiency)		
Tuberculosis			Rheumatic fever		
Whooping Cough			Surgical Operations		
Chicken Pox			Thalassemia		

If yes, write the Year of illness

History of:

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

Hospitalization no Yes, Reason: ----------Date:

Family History of: Diabetes, Hypertension ,Mental Disorder, Stroke, Tuberculosis, Other, Specify -------

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If you do not agree for vaccinations in the school, please fill the form

LETTER OF REFUSED VACCINATION IN THE SCHOOL PREMISES

Student Name: ----------

Date of Birth: ----------

Class / Grade: ----------

School Name: ---------- --

I am Mr./ Mrs. ---------- ----------(Father/Mother) of

Student ---------- ----------

This is to inform you that I have objection for my son/daughter to receive the vaccination in the school

Premises for the reason of ----------

I agree & assure to provide the school with a copy of updated vaccination record in regular basis.

Signature: ----------

Date: ----------

Telephone: ----------