SOUTH VIEW SCHOOL

Medical and Immunization Record and Consent Declaration

To be completed and returned to the School Clinic, South View School

CONFIDENTIAL

Pupil Name: .....

Date of Birth: .....

Please note that this form should be completed and returned to South View School prior to your child commencing school.

For any queries, you may contact the SVS Medical Team at clinicgroup@southview.ae

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 Academic 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?			
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

.....

.....

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, Back examination scoliosis screening, 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.**
- **This consent has to be filled each academic year and updated whenever required**

Please contact the School Doctor/Nurse if there are any queries

SOUTH VIEW SCHOOL

PARENTAL CONSENT

As the parent/guardian of .....(print child's name), I give my consent to the following:

	Yes	No	Remarks (if any)
Consent for Emergency Treatment			
In the event of your child experiencing an accident or requiring emergency treatment, the school seeks your consent for emergency first aid and potential hospital transportation. Every effort will be made to promptly communicate with you. If unsuccessful, your child will be transported to a partner hospital or clinic. In the event of continued unavailability, I hereby authorize the SVS Medical Team to make informed decisions regarding the medical and/or surgical care of my child.			
Consent for Medical Examination			
As per Dubai Health Authority (DHA) regulations, all children must undergo a medical examination within specific target groups. Our School Doctor conducts these examinations at South View School throughout the year, covering vision acuity, hearing test, back examination scoliosis screening, throat, heart, lungs, abdomen, and BMI. While the Nurse conducts annual height and weight checks. While SVS provides this service, you may choose your GP, and we require a copy of the report for the school health record. Rest assured, your child's safety is paramount, supervised by the SVS Medical Team. I grant consent for my child's school medical examinations.			
Consent for Dental Screening			
Annual Dental Screening will be conducted by a team of highly qualified, DHA Licensed General Dentist's who strictly follow the Dubai Health Authority's infection control guidelines (sterile gloves, mirrors, and dental probes for each child). A dental screening report indicating the status of your child's Oral Health will be sent to you. This report will indicate the status of your child's oral hygiene, gum condition, and whether any cavities or orthodontic disorders have been detected. This screening should not replace your child's regular six monthly dental checkups. I grant consent for my child's dental screening.			

Name of Parent: .....

Signature of Parent: ..... Date .....

(Please note that all consents are valid for the duration of time that your child attends South View School)

SOUTH VIEW SCHOOL

Consent for Administering Medication

The following are the first aid medications available in the school clinic. Please tick the medicines that you consent to being be administered to your child when necessary.

Medicine	Indication	Yes	No	Remarks (if any)
Paracetamol Syrup and Tablet	Pain and fever			
Brufen Syrup and Tablet	Pain and fever			
Zyrtec syrup	Allergic reaction			
Claritine tablet	Allergic reaction			
Buscopan tablet	Abdominal cramps			
Fenistil Gel	Itching, insect bite, burn			
Betadine	Antiseptic			
Arnical Gel	Swelling after injury, bruises, muscle pain)			
Reparil Gel	Pain, swelling after injury, muscle pain			
Medijel	Painful mouth sores			
Strepsils Lozenges (above 6 years)	Sore throat			
Fucidin Cream (antibiotic)	Cuts and wounds			
Salbutamol Nebulization	Breathing difficulty/emergency			

Name of Parent: .....

Signature of Parent: ..... Date .....

(Please note that all consents are valid for the duration of time that your child attends South View School)

SOUTH VIEW SCHOOL

MEDICATION POLICY

- All medicines should be handed to the nurse and stored safely at the clinic (as per DHA guidelines)
- Only the school nurse and doctor have the right to administer medicines.
- Parents should inform the school clinic of any treatment their child is receiving and submit a doctor's report and prescription with details of the treatment (dose and duration of the treatment).
- Parents will be required to give written consent in a Medical Form available in the school clinic for the administration of any specified medication.

☐ I understand it is my responsibility to send the medication to school in the original pharmacy container labeled with my child's name, treating physician's instructions/care plan and provide the original prescription and any other documentation to assist in the safe administration of the specified medications.

Name of Parent: .....

Signature of Parent: ..... Date .....

INFECTION CONTROL POLICY

In order to reduce the spread of illness in school, the following regulations apply.

1. Please DO NOT send your child to school if they have
   - Fever (≥ 37.5°C)
   - Unexplained skin rash that has not been assessed by a doctor.
   - Vomiting (return to school 24 hours after last episode of vomiting)
   - Diarrhea (return to school 24 hours after last episode of diarrhea)
   - Heavy nasal discharge/ runny nose
   - Strep Throat (do not return to school until they no longer have a fever, have been taking antibiotics for at least 24 hours, and have a clearance certificate of recovery from infection)
   - Persistent cough
   - Red, painful or sticky (yellow discharge) eyes (only return to school once discharge ceased).
   - Head lice/nits.
   - Consider keeping your child home, if he/she is particularly tired

2. If they have an infected or sore wound, warts or molluscum contagiosum, the affected area must be covered by a well-sealed dressing or plaster (especially during swimming or other specified activities).

3. If your child is assessed by the School Medical team and thought to be ill or a possible source of infection to others, you will be contacted to pick them up from school ASAP. They should be collected within 1 hour.

SOUTH VIEW SCHOOL

4. All children with infectious diseases should be away from school for all periods of contagiousness. Your child will be allowed to re-attend school only with a medical certificate, stating that the medical condition is no longer infectious, (It is fitness certificate with final diagnosis mentioning child is fit to attend school)

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

☐ I have read and understood the above Infection Control Policy

Name of Parent: .....

Signature of Parent: ..... Date .....

IMMUNIZATION INFORMATION

South View School administers immunizations under Dubai Health Authority for students starting from Year 2. Please attach your child's vaccination records to our file, and inform the School clinic of any new vaccines received. If your child's vaccination certificate is not in English, provide a full English translation. The SVS Medical Team will request the original vaccination record before administering school immunizations. Parents of eligible students will receive vaccination consent and a pre-vaccination checklist.

☐ I have read and understood the above.

Name of Parent: .....

Signature of Parent: ..... Date: .....