MEDICAL & IMMUNIZATION RECORD
CONSENT AND DECLARATION

Confidential

Child's Name: _____

Class: _____

Date of joining Swiss International Scientific School Dubai: _____

Name of Previous School: _____

Town / City: _____

Country: _____

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

Child's Name	
Date of Birth	
Gender	
Nationality	
Father's name	
Mobile Number	
Work Number	
Email Address	
Mother's Name	
Mobile Number	
Work Number	
Email Address	
Home telephone numbers	
Alternative Emergency Contact Name and Number	
Family doctor / Clinic Name and Contact Number	
Medical Insurance Name and Number (if applicable)	
Significant Information: Allergy / Medical Condition	
Others:	

Does your child have siblings at SISD? ☐ No / ☐ Yes

Name & Class: _____

_____

_____

Certification of Immunization

Please attach a photocopy of your child's immunization record.

The Department of School Health requires that the school maintains current information of each child's immunization history.

I confirm that the attachment is a true copy of my child's record.

Name of Student: _____
Name of Parent: _____
Signature: _____ **Date:** _____

Child's History of Illness

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

Illnesses / Conditions	YES Dates	NO	Illnesses / Conditions	YES Dates	NO
Diphtheria			Serious Accidents		
Dysentery			Allergies/ Eczema		
Infective Hepatitis			Bronchial Asthma		
Measles			Congenital Heart Disease		
Mumps			Diabetes Mellitus		
Poliomyelitis			Epilepsy		
Rubella			G6PD		
Scarlet Fever			Rheumatic Fever		
Tuberculosis			Thalassemia		
Whooping Cough			Surgical Operations		
Chicken Pox			Frequent		
ADHD			Frequent		
Nocturnal Enuresis			Vision Problems / Glasses		
Other:			Hearing Problems		

Please explain any **YES** responses to the above in more details, including treatment, medications, signs and symptoms of condition and prevention. If you have any other concerns about your child, please mention them here.

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Please continue on a separate sheet if necessary

History of: Blood Transfusion: ☐No ☐Yes Frequency: _____

Hospitalization: ☐No ☐Yes Reason: _____

Family History: (Please specify relationship to student)

☐ Diabetes _____ ☐ Hypertension _____ ☐ Stroke _____

☐ Mental Disorder_____ ☐ Tuberculosis _____

Other, please specify: _____

Confirm true and correct information

Name of student: _____

Name of parent: _____

Signature: _____

Please note that if your child commences any new medication, treatment or changes their existing medication, the School Nurse must be informed.

Consent for medical examination / routine check-ups:

According to the Department of School Health guidelines, children require a medical examination at various stages in their lives.

This service is currently offered to you by SISD. Nevertheless, if you prefer to have your child examined by your own family GP you may do so at your convenience. The school will require a copy of the doctor's report to keep on file in your child's school health record.

We would also like to reassure parents that the safety and well-being of the children are of prime importance to us and they are supervised at all times during the examination by the school nurse.

☐ **I consent my child to have medical examination at school.**

☐ **I refuse that my child receives medical examination at school.**

Name of parent: _____

Signature: _____ **Date:** _____

Swiss International Scientific School of Dubai Infection Control Policy:

In order to prevent the spread of illnesses in our school, the following regulations 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 last episode of diarrhea)
- ✓ Heavy nasal discharge
- ✓ A sore throat
- ✓ A persistent cough
- ✓ Red watery and painful eyes, especially if there is a yellow discharge.
- ✓ Head lice

2. If they have an infected sore or wound it must be covered by a well-sealed dressing plaster.

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

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

I have read and understand the above infection control policy.

Name of student: _____

Name of parent: _____

Signature: _____

CONSENT FOR ADMINISTRATION OF STANDING ORDERED SCHOOL CLINIC MEDICATIONS

In the event that the child develops a fever, pain and allergy or he/she has injured him/herself, it may be necessary to administer some medication or treatment.

As the parent/guardian of _____

(Child's full name and date of birth), IN CASE OF INJURY / ILLNESS: (please select only one of the three options with a cross)

___ **1)** I grant my authorization and consent for any medical care for my child, including the administration of the appropriate drugs for the various situations deemed necessary provided by the healthcare team in the school's clinic.

OR

___ **2)** I give permission to deliver healthcare for my child, **EXCEPT** to administer the following medication: (Please, mark with a cross, the medication that you refuse to be given to your child)

	Adrenaline (0.1ml /kg of 1: 10 000 concentration) IV, IM or SC
	Arnicare Gel (Arnica)
	Betadine Solution (10% Povidone Iodine)
	Brufen Paediatric Syrup 100mg/ 5ml (Ibuprofen) **or Brufen 200mg tab**
	Dexamethasone Syrup 20mg/ 5ml
	Elocon Cream (Mometasone cream)
	Fucidin Cream (Fusidic acid)
	Fenistil gel
	Paracetamol 120mg/5ml, 240mg/5ml or Paracetamol 500mg tab
	Pulmicort Inhalation Suspension (Budesonide)
	Reparil – Gel N

	Salbutamol Syrup 2mg/ 5ml or Salbutamol 5mg/ 2.5ml Nebulizer Solution
	Other. Please specify:_____

OR

___ **3)** I refuse any kind of medical care for my child by the school healthcare team.

I am also aware that by choosing this option and signing this form, I am releasing the Health Services of Swiss International Scientific School of Dubai of any liability or medical claims resulting from my decision to refuse care against medical advice. I further understand that my signature on this refusal form makes me completely responsible for any complication that may occur on the child.

Name of Parent: _____

Signature: _____ **Date:** _____

If you change your mind, or your conditions changes, you can always contact with the School Clinic.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

As the parent/guardian of _____

(Child's full name and date of birth – DD/MM/YY), IN CASE OF INJURY / ILLNESS: (please select only one of the three options with a cross):

a) ☐ I authorize the School Clinic to disclose the school health record of my child to any healthcare provider in case of an emergency situation and if transportation is needed.

b) ☐ I authorize the School Clinic to disclose the school health record of my child to any healthcare provider **ONLY** at my request

c) ☐ I don't authorize the School Clinic to disclose the school health record of my child.

Right to revoke authorization

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the School Clinic. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Name of the parent (legible): _____

Signature: _____ **Date:** _____