



Medical and Immunisation Record and Consent Declaration

To be completed and returned to the School Nurse, Repton School, Dubai

CONFIDENTIAL

Pupil Name

Date of Birth *DD/MM/YY*

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

Dear Parents,

The Ministry of Health require all schools to keep an up-to-date medical record of their pupils and also a register of every child's immunisation history. Therefore, this document forms an important part of the admissions process to Repton School. Please make sure that you complete this health information form accurately and return it to the school nurse.

The form is split into several sections. Please complete all sections as fully a possible and attach a photocopy of your child's immunisation record for our records.

The information provided will remain confidential. Should you have any queries, please feel free to contact the school nurse. She will be happy to answer any questions you may have.

Name of pupil:		Year Group:	
Gender:		D.O.B.	
Nationality:		Residential phone number	
Mothers name:		Fathers Name	
Mothers Mob:		Fathers Mob.	
Emergency Contact:			
Family Doctor/Clinic Name:		Previous School	

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

Illness	Yes	No	Date	Condition	Yes	No	Date
Chicken Pox				ADHD			
Diphtheria				Eczema			
Dysentery				Bronchial Asthma			
Infective Hepatitis				Congenital Heart Disease			
Measles				Diabetes Mellitus			
Mumps				Epilepsy/Seizures			
Poliomyelitis				Frequent Gastric Problems			
Rheumatic Fever				Frequent Headaches			
Tuberculosis				Tourette syndrome			
Whooping Cough				Nocturnal Enuresis			
Other (please specify)				Serious Accidents			
				Surgical Operations			
				Thalassaemia			
				Vision Problems/Glasses			
				Other			

Please provide further information to any YES responses above, including treatment and medications.

(Please continue on separate sheet if necessary)

Please advise if there is a family history of the following:

	Yes	No		Yes	No
Diabetes			Tuberculosis		
Hypertension			Other (please specify)		
Stroke			Psychological disorders		

Please indicate if your child:-

1. Has been hospitalised for any reason.
2. Has any allergy.
3. Wears glasses or has any visual problems.
Date of last eye test
4. Has any hearing difficulty.
Date of last ENT visit where applicable.....
5. Takes medication on a regular basis.
6. Has ever required a blood transfusion.
7. Has any physical disability.
8. Has previously had occupational play therapy.....
9. Has previously had speech and language therapy.....

Please provide copies of Doctors/ Therapists reports.

CERTIFICATE OF IMMUNISATION

Please include all details of your child's immunisations including date administered.

Type of Immunisation	1 st Dose Date	2 nd Dose Date	3 rd Dose Date	Booster Date	Remarks
BCG					
BCG Screening					
DPT*					
OPV (Oral Polio)					
DT**					
MMR***					
HBV (Hep B)					
Measles					
Hib°					
Rubella					
Chicken Pox					
Other:					

* DPT Diphtheria, Pertussis (whooping-cough) and Tetanus Hib° Haemophilus influenzae type b

**DT Diphtheria and Tetanus

***MMR Mumps, Measles and Rubella

In addition **please attach a photocopy of your child's immunisation record** for verification.

Please delete as appropriate.

I **give consent/do not give consent** for the immunization of my child in school.

This information is mandatory as per DHA (Dubai Health Authority) regulations.

Name of Pupil: _____

Name of Parent: _____

Signature of Parent: _____

Date: _____

PARENTAL CONSENT FOR THE ADMINISTRATION OF PARACETAMOL AND SIMPLE MEDICATION

Name of Pupil: _____

Administration of Paracetamol

In the event that your child develops a fever or has pain, it may be necessary to administer Paracetamol. If your child is unable to take this medication, please contact the school nurse to discuss the use of an alternative.

I consent / do not consent (**delete as applicable**) to my childbeing given Calpol/ Paracetamol should it be considered necessary by the School Nurse, Matron or House Master /Tutor.

Name of Parent: _____

Signature: _____

Date: _____

Should your child feel unwell and require simple medication such as throat lozenges or arnica for a bump, we also require your permission to administer. A full list of the simple medications that shall be used at Repton School can be obtained from the nurse's office.

I do /do not (**delete as applicable**) give permission for my childto be administered simple medication should they require it.

Name of Parent: _____

Signature: _____

Date: _____

Medication prescribed by a Doctor may need to be administered during the school term. For this to take place, parents will be required to give consent for the administration of specified medication. A consent form for this purpose can be obtained from the School Nurse or Matron. Information required will include the child's name, medication required and precise instructions regarding administration of the drugs. No medication will be administered by the nurse unless this form has been completed. Medication may be administered by the School Nurse, Matron or House Tutor.

If your child has a history of asthma or allergic condition requiring the use of inhalers, nebulisers or an epipen, it is important that a spare is kept at the school. This then can be given in an emergency situation with prior written consent from the parent.

EMERGENCY TREATMENT

In the event that your child has an accident or requires emergency treatment, the school requires permission to administer emergency first aid and if required, arrange transport to hospital for diagnosis and treatment. In such cases every attempt will be made to contact you as quickly as possible.

If we are unable to contact you, your child will be taken to a doctor/hospital for diagnosis and treatment. Efforts to contact you will continue. Our policy is to take a child to **Rashid Hospital**. If you have an alternative preference, please indicate below and we will do our best to adhere to your requirements.

Name of Parent: _____

Signature: _____

Date: _____

Please also provide the following details:

Health Card No.: _____

Insurance Company: _____

Preferred Hospital: Rashid (Y/N) _____

Other (please specify) _____

Consent for Medical Examination

It is the requirement of the Department of Health and Medical Services that all children have a medical examination when they are new to a school, in Year 1, Year 5 and Year 9.

Our School Doctor will carry out the medical examination at Repton throughout the school year. The examination includes measurement of height and weight, screening of vision and examination of ears, throat, heart, lungs and abdomen.

Please complete and sign below. If you do not consent to the medical being carried out at the school, you must have it done privately by your own doctor and provide a medical report for your child's file.

Name..... Form

I consent / do not consent (delete as applicable) to my child (name) being examined at school.

Signed Date

Printed

Letter for 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 Number: