Greenfield Community School

Medical Information Pack

Confidential

Mandatory: Please complete this form and return it prior to your child starting at Greenfield Community School.

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Greenfield Community School

Medical Information Pack

Please place a passport-size photograph here.

IMMUNISATIONS

The Department of Health requires accurate vaccination records on each child registered within the Dubai Municipality School System. It is essential that we are able to present them with an accurate record of each child's immunisation status. Please supply a copy of your child's vaccination certificate with this form.

Dubai Health Card No._____

Child's Name: _____ **Date of Birth:**_____

Nationality: _____ **Gender:** _____ **Class/Year:** _____

Father's Name: _____ **Mother's Name:** _____

Address: _____

_____

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

Father's Mobile No.: _____ **Mother's Mobile No.:** _____

Child's Medical History

Please tick appropriately and specify details.

INFECTIOUS DISEASE	YES	DETAILS/YEAR
Diphtheria		
Dysentery		
Infective Hepatitis		
Measles		
Mumps		
Poliomyelitis		
Rubella		
Scarlet Fever		
Tuberculosis		
Whooping Cough		
Chicken Pox		
Other		

DISEASE/CONDITION	YES	DETAILS/YEAR	TREATMENT
Accidents			
Allergies			
Bronchial Asthma			
Congenital Heart Disease			
Diabetes Mellitus			
Epilepsy			
G6PD			
Rheumatic Fever			
Surgery			
Thalassemia			
Immunocompromised			
Other			

History of: Blood Transfusion No ☐ Yes ☐ Details/Year:_____

Hospitalisation No ☐ Yes ☐ Reason: _____

Family History:

Diabetes / Hypertension / Mental Disorders / Stroke / Tuberculosis / Other, please specify: _____

Currently using: Braces _____ Crutches _____ Eyeglasses/Contact Lenses _____

Certificate of Immunisation

Please complete clearly all details of your child's Immunisation Record and insert the dates the immunization was given:

TYPE OF IMMUNISATION	1st DOSE	2nd DOSE	3rd DOSE	BOOSTER	REMARKS
BCG					
BCG Screening (Manteaux Test)					
Hepatitis B					
DPT					
Polio					
Hib					
Measles					
MMR					
D.T.					
Chicken Pox					
Rubella					
Other:					

Vaccination Record

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

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

Consent for Medical Examination

The Dubai Department of Health regulations require that every child attends a medical as follows:

- **School entry, including entry to the Dubai School system**
- **Grade 5**
- **Grade 9**
- **School leaving**

These examinations will take place throughout the year. Your consent is required; however, if you prefer to have your child examined by your family doctor, you may do so at your convenience. Please provide the school with a copy of the medical examination report for your child's file.

It is not necessary to attend, however, if you wish to do so, please tick the appropriate box below. We will contact you when your child is scheduled for the medical examination.

I consent to my child having medical examinations at the school: Yes ☐ No ☐
I would like to be present during the examination: Yes ☐ No ☐

Guardian/Parent Name: _____

Signature: _____ Date: _____

Mobile Number: _____

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: _____

Signature: _____ Date: _____

Accident/Emergency Consent

In the event of an emergency or accident where you 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 consent to allow us to transfer your child to the accident and emergency department of the nearest facility. Please sign below.

Guardian/Parent Name: _____

Signature: _____ Date: _____

Emergency Contact: _____

Prescription Medications

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

Medication Name: _____

Medication Dosage: _____

Diagnosis requiring medication: _____

Medication Name: _____

Medication Dosage: _____

Diagnosis requiring medication: _____

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 to the school's nurse: ☐

As far as we are aware, the school still has the file: ☐

حكومة دبي
GOVERNMENT OF DUBAI

هيئة الصحة بدبي
DUBAI HEALTH AUTHORITY

PRIMARY HEALTH CARE
SCHOOL HEALTH SERVICES
P.O. Box: 1899- Dubai

CONSENT FOR IMMUNIZATION

Name of the Child: _____
Date of Birth: _____
Name of the School: _____
Class/ Grade: _____

Please tick (√)

□ I give the consent for the Immunization of my child
□ I do not agree for immunization of my child

Name and Signature: _____

PARENT AND GUARDIAN

P.O. Box: _____
Telephone Number: _____

Dear Parents
Please provide the following information to update
Your child's School Health Record and sends his/her
ORIGINAL IMMUNIZATION CARD

CHILD'S HISTORY OF ILLNESS:
Please tick (√) appropriately
If yes, specify Month/ Year of illness.

Infectious Diseases	Yes	No
Diphtheria		
Dysentery		
Infective Hepatitis		
Measles		
Mumps		
Poliomyelitis		
Rubella		
Scarlet Fever		
Tuberculosis		
Whooping Cough		
Chicken Pox		

Non- Infectious Diseases	Yes	No
Accidents		
Allergies		
Bronchial Asthma		
Congenital Heart Disease		
Diabetes Mellitus		
Epilepsy		
G6PD		
Rheumatic Fever		
Surgical Operations		
Thalassemia		

If yes write the year of illness:
History of: Blood Transfusion □ No □ Yes, Frequency _____
Hospitalization □ No □ Yes, Reason: Date: _____

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

_____
Licensed School Nurse

DOH/PHC/SHS

هـيئـــة الصحـــة بدبـــي
DUBAI HEALTH AUTHORITY

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: ……