ASIAN INTERNATIONAL PRIVATE SCHOOL

RUWAIS / MADINAT ZAYED / MADINAT ZAYED (BRANCH 2), KING & QUEEN NURSERY (ABU DHABI)

STUDENT MEDICAL DATA &HEALTH DECLARATION FORM

FOR ACADEMIC YEAR 20___ TO 20___

TO BE FILLED IN BLOCK LETTERS:

NAME OF THE STUDENT		
DATE OF BIRTH AND AGE (IN FIGURES)		
FATHER'S NAME		
FATHER'S CONTACT NUMBER		
MOTHER'S NAME		
MOTHER'S CONTACT NUMBER		
CONTACT INFORMATION	**EMERGENCY CONTACT**	
	HOME	
	OFFICE	
	MOBILE	

Please complete the following questions:

If your child does suffer from any of the medical conditions mentioned below, what medication is prescribed?

DESCRIPTION	TICK	MEDICATION
ASTHMA		
DIABETES MELLITUS		
EPILEPSY		
ECZEMA		
HAY FEVER		
HYPOTENSION		
HYPERTENSION		
CHRONIC ILLNESS – IF ANY (in case of chronic illness attach a medical report)		
CHRONIC REPIRATORY ILLNESS – IF ANY		
KIDNEY ILLNESS		
LIVER DISEASE		
AUTOIMMUNE DISEASE		
HAEMATOLOGICAL DISORDER		
ALLERGIE: DRUGS, FOOD ETC..		
Any Thyroid Disorder		
ORTHOPEDIC		
DYSLEXIA		
JAUNDICE		
DIARRHEA		
CARDIAC DISEASE		
ANEMIA		
HAEMOPHILIA		

Has your child had taken anti-coagulant medicines (E.g. Aspirin) any time earlier? ☐Yes ☐No

OR

Now under this medication? ☐Yes ☐No

If 'YES' please give details including the name of the medication and its duration with start and end along with the dates, month and year

_____

Is your child on any immunosuppressant medication? ☐Yes ☐No

If 'YES' please give details including the name of the medication and its duration with start and end along with the dates, month and year.

_____

_____

_____

Psychological Conditions, specify if any _____

_____

_____

Any medications related to psychological conditions (anti-depressants, psychoactive drugs, sedatives, please specify)

GENERAL MEDICAL HISTORY

MEDICAL DISORDERS

DESCRIPTION	YES	NO
CARDIAC		
ORTHOPEDIC		
URINARY		
HEARING		
GLAUCOMA		
OTHERS		

EYE VISION DETAILS

VISUAL ACUITY	EYE VISION SCALE
MYOPIA/NEAR SIGHTEDNESS	
ASTIGMATISM	
HYPEROPIA/FAR SIGHTEDNESS	
PRESBYOPIA/ READING GLASSES	

ALLERGIES

ALLERGIES	SPECIFY	OCCURRED DATE, MONTH ,YEAR & DURATION
MEDICINES / DRUGS		
FOOD		
OTHERS		

ANY SERIOUS ILLNESS IN THE PAST? ☐ **YES** ☐ **NO**

IF 'YES' PLEASE GIVE DETAILS

_____

_____

ANY SERIOUS NOVEL CORONAVIRUS ILLNESS IN THE PAST? ☐ **YES** ☐ **NO**

IF 'YES' PLEASE GIVE DETAILS

_____

_____

HAS ANYONE IN YOUR HOUSEHOLD BEEN DIAGNOSED WITH COVID-19? ☐ **YES** ☐ **NO**

IF 'YES' PLEASE GIVE DETAILS _____

HAS YOUR CHILD, IN THE PAST 14 DAYS, COME IN CLOSE CONTACT WITH SOMEONE DIAGNOSED WITH COVID-19? ☐ **Yes** ☐ **No**

HAS YOUR CHILD HAD ANY FEVER OR RESPIRATORY SUMPTOMS "COUGHING, SNEEZING, LOSS OF THE SENSE OF THE SMELL OR TASTE, TROUBLE BREATHING, HEADACHE, SORE THROAT, RUNNY OR STUFFY NOSE" IN THE PAST 3 DAYS? ☐ **Yes** ☐ **No**

HAS ANYONE IN YOUR HOUSEHOLD TRAVELLED TO ANY OTHER COUNTRY IN THE PAST 21 DAYS? ☐ **Yes** ☐ **No**

IF YES PLEASE SPECIFY _____

_____

ANY SURGERIES? ☐ **YES** ☐ **NO**

IF 'YES' PLEASE GIVE DETAILS (INCLUDE DATE, MONTH AND YEAR)

_____

_____

_____

BIRTH DEFECT IF ANY, SPECIFY _____

HANDICAPS/DISABILITIES/AUTISTIC IF ANY, SPECIFY BELOW

HEREDITARY DISORDERS i.e., PARENTS/GRANDPARENTS, ETC., IF ANY SPECIFY BELOW

☐ **Yes** ☐ **No**

HAS YOUR CHILD HAD THE FOLLOWING VACCINATION?

DESCRIPTION	YES	NO	DATE, MONTH & YEAR
BCG			
DIPHTERIA			
WHOOPING COUGH			
TETANUS			
MUMPS			
MEASELS			
RUBELLA			
MENINGITIS			
HEPATITIS – B			
POLIO			
CHICKEN POX			
OTHERS			

HAS YOUR CHILD SUFFERED FROM THE FOLLOWING?

DESCRIPTION	YES	NO	DATE,MONTH, YEAR & DURATION
MUMPS			
MEASLES			
RUBELLA			
CHICKEN POX			
HEPATITIS – B			
POLIO			
MENINGITIS			
OTHERS			

PERSONAL FITNESS RECORD

DATE	DOB	HEIGHT	WEIGHT	BLOOD GROUP	PLACE OF BIRTH

MEDICAL RELATED INFORMATION DETAILS

_____

_____

_____

SELF DECLARATION BY THE PARENT

I, the undersigned, dated _____, parent/legal guardian of _____ (name of the student & grade), I (name of the parent) _____ , Emirates ID Number_____, hereby confirms that the above provided information in this declaration form is correct, true and complete.

IN CASE ANY OF THE ABOVE INFORMATION IS FOUND TO BE FALSE, UNTRUE, MISLEADING, OR MISREPRESENTING, I TAKE COMPLETE RESPONSIBILITY OF THE SAME AND I AM AWARE THAT I MAY BE HELD LIABLE FOR THE LEGAL CONSEQUENCES SUBJECTED TO THE APPROVAL OF REGULATORY BODIES.

IF ANY OF THE ABOVE INFORMATION ABOUT MY CHILD OR HOUSEHOLD CHANGES, I WILL IMMEDIATELY NOTIFY THE SCHOOL NURSE.

I HEREBY UNDERTAKE THAT NOT TO SEND MY CHILD TO SCHOOL IF HE DEVELOPS ANY COVID-19 SYMPTOMS.

I HEREBY UNDERTAKE AND ASSURE THE SCHOOL THAT MY CHILD WILL WEAR MASK, GLOVES AND FACE SHIELD DURING SCHOOL HOURS.

Please contact me at the above telephone number to obtain my permission before you administer common medication to my child.

Signature of the Parent : _____

Date of signature : _____

Note :

- You are advised to provide any additional Health/Medical related information you wish to bring to the School's attention/School Nurse.
- If you find any difficulty related to the terminology please contact the School Nurse for the explanation