Our Ref. Admin 4 Medical Form

SHARJAH ENGLISH SCHOOL

Student Medical Report

For Official Use only	
YEAR	

Please complete the following details as fully as possible; this information will greatly assist staff when dealing with illness/accidents during school hours.

Personal Details

Name in Full		
Date of Birth (d/m/y)		
Telephone no.	Res.	
Mum	Work	Mobile
Dad	Work	Mobile
Languages Spoken	1st	2nd

Ability in Water

Is your child a swimmer?	Yes / No (please circle one)	Can your child swim 25 metres?	Yes / No (please circle one)

Emergency Contact Details (person to call if we are unable to contact parents)

Name	Relationship to child
Telephone no.	

Consent for treatment

In the event of an emergency, if the parent or guardian cannot be reached, we require permission to take the student to a hospital if deemed necessary.
(Please be aware that your child will be taken to **Sharjah University Hospital.** This is the closest hospital to the school that has an emergency facility. This is a private hospital and the cost of the care will be the parent's responsibility.)

Does your child have medical insurance?	Yes / No (please circle one)
Permission to administer non-prescriptive medicines, e.g. simple linctus and throat lozenges.	Yes / No (please circle one)
Permission to administer first aid.	Yes / No (please circle one)

In the event of an emergency, if the parent/guardian cannot be reached, permission is given to take the student to a hospital if deemed necessary.	Yes / No (please circle one)
In the event of an emergency, the school is authorised to call for an ambulance service. (The National Ambulance Service will be used. Parents / guardian will be contacted and advised whenever this is deemed necessary.)	Yes / No (please circle one)
Signature of parent/guardian	Date:

Known Allergies		Known Medical Conditions	
Nil Known	Yes / No (please circle one)	Nil Known	Yes / No (please circle one)

If your child has known allergies/Medical Conditions, please complete the following details.

Allergy	Reaction	Treatment
Medical Conditions	**Treatment**	**Parent Signature**

Immunisation History

Please attach a photocopy of your child's vaccination record or fill in the sheet below. **This is a directive from the Ministry of Health** and is very important that the school nurse receives this when your child starts their first day at SES.

Vaccine	1st Date	2nd Date	3rd Date	Follow up date	Notes
Polio					
D.P.T.					
HIB					
T.B. Antigen					
B.C.G.					
M.M.R.					
Meningovac					
Hepatitis A					
Hepatitis B					
Varicella					

Please provide details of any other immunisations given:

Immunisation	Date Given	Immunisation	Date Given	Immunisation	Date Given

BCG/TB		Typhoid		Hep A	
Rubella		Yellow Fever		Hep B	

Other Health Problems

Please indicate (by ticking the applicable box) whether your child has experienced any of the following health problems. If you answer 'yes' to any question, please provide full details in the space below. Please include any additional information that you feel is relevant.

□ Chicken Pox	□ Asthma	□ Visual problems
□ Measles	□ Eczema / Skin problems	□ Ear / Hearing problems
□ Mumps	□ Diabetes	□ Heart problems
□ Rubella	□ Convulsions / Epilepsy	□ Kidney problems
□ Tuberculosis	□ Hospitalisation	□ Orthopaedic problems
□ Whooping Cough	□ Speech difficulties	□ Regular medication *
□ Malaria	□ Learning difficulties	□ Unable to participate in all school extra-curricular activities, including sports / PE

Further details:

* If your child requires medication during school hours, please inform the nurse in writing of the medication dose required and the time required to take the medicine. Please include a signed consent.

NO CHILD SHOULD BE ALLOWED TO ADMINISTER MEDICINE THEMSELVES. ALL MEDICATION SHOULD BE HANDED IN TO THE SCHOOL NURSE AND SHOULD BE CLEARLY LABELLED. No medicines sent or given to the school should be beyond its expiry date.

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