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Public Health Sector, Population Health and Epidemiology Department
(School Health Programme)

Student Medical Information and Consent

Student Photo	**Dear Parent/Guardian of the Student,** Please fill in the following form accurately to help us maintain and monitor your child's health and wellbeing during the academic year. If any answer is Yes, please provide us with dates and details.

School Information			
School Name:		**Grade/Year:**	
		Section:	

Student Information			
Student Full Name:		**Gender:**	
Date of Birth:		**Nationality:**	
Parent or Legal Guardian Name:		**Relationship to Student:**	
Religion:		**First Language:**	
Mobile Number (1):		**Mobile Number (2):**	
Email:		**Emirate:**	

In case of emergency, if we are unable to reach the parent/guardian, the following person can be contacted:					
Name:		**Relationship:**		**Mobile Number:**	

Required Attachments			
Student's Emirates ID Copy	☐ Yes	☐ No	**Emirates ID Number:**
Student's Passport Copy	☐ Yes	☐ No	
Original Vaccination Card or Updated Copy	☐ Yes	☐ No	
Health Card Copy (if any)	☐ Yes	☐ No	**Health Card Number:**
Health Insurance Card Copy (if any)	☐ Yes	☐ No	

Student Medical History				
	Health Problem	**Yes**	**No**	**Comments**
1	Does the student have any allergies to medicine, food, dust, etc.? If yes, please specify in comments			
2	Does the student have any cardiovascular problem?			
3	Does the student have diabetes?			
4	Does the student have hypertension?			
5	Does the student have bronchial asthma?			
6	Does the student have any renal problem?			
7	Has the student suffered from recurrent urinary tract infections?			
8	Does the student have epilepsy or convulsions/seizures?			
9	Does the student have epistaxis (nosebleeds)?			
10	Does the student have G6PD deficiency?			
11	Does the student have any hereditary blood disease (e.g. thalassaemia, sickle cell anaemia, haemophilia)? If yes, please specify in comments			
12	Does the student have any skin problem?			
13	Does the student have any eye problem (e.g. myopia, hyperopia)? If yes, please specify in comments			
14	Does the student have any hearing problem?			
15	Does the student use any medical aid device? If yes, please specify the device details in comments			
16	Has the student had any surgery in the past? If yes, please specify the details in comments			
17	Has the student ever been hospitalised? If yes, please specify the reasons in comments			
18	Does the student have any health condition that could weaken the immune system such as cancer (blood cancer, lymphoma) or an organ transplant? If yes, please specify in comments			
19	Has the student ever received a blood, antibody or plasma transfusion?			
20	Has the student had any of the following diseases: mumps, measles, diphtheria, pertussis (whooping cough), chickenpox or tuberculosis? If yes, please specify details in comments			
21	Has the student had viral hepatitis?			
22	Has the student had poliomyelitis (polio)?			
23	Does the student have any mental health or behavioural problem? If yes, please specify in comments			
24	Does the student have any other health problem or disease not mentioned here? If yes, please specify in comments			

If the student suffers/suffered from any of the health problems mentioned or not mentioned above, please answer the following questions:

Medications or Treatments taken continuously					
1. Medical Condition:					
Name of Medication:					
Dosage:		**Frequency:**		**Route (by mouth, inhaler, injection):**	
2. Medical Condition:					
Name of Medication:					
Dosage:		**Frequency:**		**Route (by mouth, inhaler, injection):**	
Emergency Medications					
Name of Medication:					
Dosage:		**Frequency:**		**Route (by mouth, inhaler, injection):**	
Any instructions from the treating doctor on the student's nutrition (dietary recommendations)					
Any instructions from the treating doctor on the student's physical activity and exercise (physical activity recommendations)					
Any instructions or recommendations from the treating doctor for the school medical team to follow during school hours.					

Family Medical History

	Health Problem	Yes	No	Comments
1	Any cardiovascular problem or hypertension			
2	Diabetes			
3	Any hereditary blood disease (e.g. thalassaemia, sickle cell anaemia, haemophilia)			
4	Any type of cancer			
5	Any immune system problem			
6	Any mental health problem			
7	Other (please specify in comments)			

Consent for School Health Screening and Medical Services

This form explains the essential health screenings and medical care provided at school. By giving approval for each screening or school service, you authorise your child to receive essential healthcare provided by DHA-licensed healthcare professionals. Please complete the consent table below according to the student's grade/year.

Please tick (✓) either Approve or Reject for each service and health screening. If Reject is selected, please specify the rejection reason.

SCHOOL HEALTH SERVICE/MEDICAL SCREENING	GRADE/YEAR	APPROVE	REJECT	REJECTION REASON
First Aid Care, Emergency Room Referral and Emergency Medication	All Grades/Years	☐	☐	
Height and Weight Measurement and Body Mass Index (BMI)	All Grades/Years	☐	☐	
Vision Screening	All Grades/Years	☐	☐	
Hearing Screening	Mandatory: Grade 1/Year 2 Recommended: Grade 3/Year 4 and Grade 5/Year 6	☐	☐	
Dental Check-up	New Admission, Grade 1/Year 2, Grade 5/Year 6 and Grade 9/Year 10	☐	☐	
Fluoride Varnish Programme	Grade 1/Year 2, Grade 2/Year 3 and Grade 3/Year 4	☐	☐	
Supervised Toothbrushing Programme	KG1/FS2 and KG2/Year 1	☐	☐	
Back Examination (Scoliosis Screening)	Grade 5/Year 6 (female) and Grade 9/Year 10 (male)	☐	☐	
Comprehensive Medical Examination, including vital signs (temperature, pulse, respiration and blood pressure)	New Admission, KG1/FS2, Grade 1/Year 2, Grade 5/Year 6 and Grade 9/Year 10	☐	☐	
Mental Health Screening (Attention Deficit Hyperactivity Disorder, ADHD)	Grade 1/Year 2 (if recommended after teacher observation)	☐	☐	
Mental Health Screening (Depression)	Grade 9/Year 10	☐	☐	
Smoking Screening	For students aged 11 years and above	☐	☐	
Blood Test – Complete Blood Count (CBC). The purpose of this test is to detect anaemia	Grade 1/Year 2 (male and female) and Grade 9/Year 10 (female)	Complete blood count (CBC) should be performed for targeted students at a licensed healthcare facility, and the parent/guardian must submit the CBC results to the school clinic.		

- A genital examination is required once for students in Grade 1/Year 2 and once in Grade 5/Year 6 as part of the Comprehensive Medical Examination to assess normal development and identify any medical concerns. However, to maintain students' privacy, this examination will not be conducted in the school setting. Parents/guardians are advised to arrange the examination with their child's treating physician or at the nearest health center during the applicable grade/year.
- Mental Health Screening: Attention Deficit Hyperactivity Disorder (ADHD) for Grade 1/Year 2 students. The teacher will refer students with suspected ADHD to the school nurse, who will send a questionnaire to both the teacher and the parent/guardian. The parent/guardian will be informed and will receive a referral letter to seek medical care if either questionnaire is positive.

Parent/Guardian Acknowledgement

☐ I certify that the information provided is accurate.

☐ I acknowledge the need to inform the school medical team of any changes in health status and submit the required medical reports accordingly.

Parent/Guardian Name:		**Relationship:**	
Parent/Guardian Signature:		**Date:**	

Notes

- Please attach any medical reports on the student's health problems.
- It is the responsibility of the student's parent/guardian to inform the school clinic of any changes in the student's health status and submit medical reports accordingly to update the student's medical record at school.
- After the school screening, the parents/guardian of any student with abnormal test results will receive a referral letter advising them to book an appointment with a specialist doctor.
- This consent form must be completed each academic year and updated whenever required.
- All data related to the results of the Comprehensive School Health Screening Programme will be shared with relevant government authorities where required and handled confidentially in line with applicable data protection laws.

Please contact the school doctor or nurse if you have any questions.

Authorization of Drugs Administration:

During school days, children may have fever, pain and injury. School Doctors & Nurses are giving care and treatment according to needs. Read the list below. If a drug is contraindicated for your child, please inform us as soon as possible and provide an alternative medicine.

S. No	Name of the Drug	Age	Dose
1	**Fever & Pain**		
	Panadol syrup (Pink)	1-4 years	120mg/5ml
	Panadol syrup (Blue)	5-12 years	240mg/5ml
	Panadol tablets	10 years & according to weight	500mg to 1g
	Brufen tablets	10 years & according and weight	400 and 600mg
	Brufen syrup	3-12 years	100mg/5ml
2	**Allergy**		
	Aerius Syrup	3-12 years	5mg/5ml
	Zyrtec Syrup	3-12 years	10mg
3	**Abdominal spasm/Pain & Gas**		
	Hyopan Syrup	3-12 years	5mg/5ml
	Buscopan tablet	Above 6 years	10mg
	Pediacol	3 years and above	40mg/ml
4	**Trauma & Muscle Pain**		
	Arnical gel	All	Topical Application
	Voltaren gel		
5	**Topical Antibiotic/Corticosteroid**		
	Fucicort cream	All	Topical Application
	Fucidin cream		
	Bepanthen Plus Antiseptic Wound		
6	**Insect bite & Allergy**		
	Fenistil Gel	All	Topical Application
7	**Mouth ulcers & Gums sore**		
	Gengigel	All	Topical Application
8	**Eye Irritation**		
	Systane ultra (eye drops)	All	1-2 drops
	Naphcon- A		
9	**Burn**		
	Mebo cream	All	Topical Application
10	**Disinfection for wound**		
	Betadine	All	Topical Application
	Hansaplast Wound Spray		
	Bepanthen		
11	**Moisturizing cream**		
	Cetaphil	All	1-2 drops
	Bepanthen		
11	**Cough,Sore throat & Mouth wash**		
	Strepsil	6 years and above	1 lozenge
	Betadine Lozenge		1 lozenge
	Zecuf Lozenge		1 lozenge
	Betadine Mouthwash		Gargle
12	**Nausea/Vomiting/Diarrhea**		
	Motilium (Domperidone) Syrup	All	According to weight
	Enterogermina		1 amp oral

Please tick:

☐ I give permission that my child can take above medicines from the school clinic.

☐ I don't give permission that my child can take above medicines from the school clinic.

Note:

Please write if your child is allergic to a specific medicine. If you will give medication to your child in the morning before coming to school, please inform us.

Signature: _____ Date: _____