Delhi Private School Dubai
SCHOOL HEALTH RECORD

In order to complete your child's DPS Dubai Medical Record please provide the following details:

Student's Name: .....Grade :.....

Male ☐ Female ☐

Emirates ID ..... Medical Insurance Details ----------

Nationality---------- Date of Birth ---------- (dd/mm/yy)

Mother's Name ---------- Mother's Tel No ---------- Fax No/ Email ----------

Father's Name ---------- Father's Tel No ---------- Fax No/ Email ----------

Residence Address ----------

Residence Tel No. ---------- ----------

HEALTH INFORMATION

1.	Does your child have any known medical problem or disability?	Yes ☐	No ☐
2.	Does your child wear glasses or contact lenses?	Yes ☐	No ☐
3.	Does your child have any hearing difficulties?	Yes ☐	No ☐
4.	Does your child take any medication other than vitamins?	Yes ☐	No ☐
5.	Does your child have any allergies?	Yes ☐	No ☐

If you have answered YES to any of the above, please provide further details and indicate clearly whether this condition will, in your opinion, affect your child's ability to participate in any aspect of school life, EG regular classes, sport classes, field trips, after school activities etc.

Signs and Symptoms: ----------

Medication taken to prevent further reaction: ----------

Other information: ----------

6. Name of the previous School in Dubai (if one attended): ----------Grade/Sec: ----------

7. Consent given for medical examination by School Doctor or Nurse? Yes ☐ No ☐

8. Has the child been vaccinated for COVID-19? Yes ☐ No ☐

Name of the COVID-19 vaccine taken:.....

Date/s of Vaccination: 1st Dose: ..... 2nd Dose: .....

Please enclose:

9. **One Passport-sized photograph of your child.**
10. **Copy of vaccination records including COVID-19 vaccination record**.

Delhi Private School Dubai

CONSENT FOR EMERGENCY TREATMENT

In the event that my child requires emergency treatment, I will be contacted and asked to collect my child from the school.

If the school is unable to contact me, my child will be taken to a doctor or hospital for diagnosis and treatment. Efforts to contact me will continue.

I consent to my child being taken to a doctor or hospital in the event of a medical emergency.

Name of Parent: ----------Signature: ---------- Date: ----------

MEDICAL TREATMENT – PARACETAMOL

Student's Name ---------- Grade ---------- Section ----------

I consent to my child being given Paracetamol, should be it be considered necessary by the school doctor or nurse.

If your child is unable to take this medication, please contact the school doctor or school nurse to discuss the use of an alternative medication.

The medical staff will contact you if there are any concerns.

Name of the Parent: ----------Signature: ----------Date: ----------

DELHI PRIVATE SCHOOL INFECTION CONTROL POLICY

In order to reduce and minimize the spread of illnesses in the school, the following regulations shall apply.

1. Please do not send your child to school if they have:
   - Fever
   - Skin rash
   - Vomiting (not to return to School for 24 hours after the last vomiting episode)
   - Diarrhea (not to return to School for 24 hours after the last diarrhea episode)
   - Persistent cough
   - Heavy nasal discharge
   - Red, watery and painful eyes
2. An infected sore or wound must be covered by a well-sealed dressing or plaster.
3. If your child is assessed by the School Doctor and/or School Nurse, and deemed to be a possible source of infection to other students, you will be contacted to take the child home immediately.

Please inform the School if your child has been or is being treated for a medical Condition.

I have read and understand the above Infection Control Policy.

Name of parent: ----------Signature: ---------- Date: ----------

Please confirm by signing that you have read the School Clinic Policy www.dpsdubai.com

Public Health Protection Department- School Health Section

Student Medical Form & General Consent

Student Photo

Dear Parent/ Guardian of the Student:

Please fill the following form accurately to ensure maintaining and monitoring your child's health and wellbeing during the school Academic year

School Information

School Name: ..... Grade: ..... Section: .....

Student Information

Student Full Name: ..... Gender: .....
Date of Birth: ..... Nationality: .....
Parent or Legal Guardian Name: ..... Relationship: .....
Mobile Number (1): ..... Mobile Number (2): .....
E-Mail: ..... Emirate: .....
In case of Emergency and 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	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 suffer from any allergy to medicine, food, dust, etc.? If yes, please specify in comments			
2	Does the student suffer from any Cardiovascular problem?			
3	Does the student suffer from Diabetes?			

4	Does the student suffer from Hypertension?			
5	Does the student suffer from Bronchial Asthma?			
6	Does the student suffer from any Renal Problem?			
7	Does the student suffer from Epilepsy or Convulsion /seizures?			
8	Does the student suffer from Epistaxis?			
9	Does the student suffer from Hemolytic Anemia, type G6PD?			
10	Does the student suffer from any Hereditary Blood Disease (e.g. Thalassemia, sickle cell anemia, Hemophilia)? If yes, please specify in comments			
11	Does the student suffer from any Skin Problem?			
12	Does the student suffer from any Eye problem (Myopia, Hyperopia…)? If yes, please specify in comments			
13	Does the student suffer from any Hearing problem?			
14	Dose the student use any medical aid device? If yes, please specify the device details in comments			
15	Did the student undergo any surgery in the past? If yes, please specify the details in comments			
16	Was the student ever hospitalized? If yes, please specify the reasons in comments			
17	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			
18	Did the student get any blood, antibodies or plasma transfusion in the past?			
19	Did the student suffer from any of the following diseases: (Mumps, Measles, Diphtheria, Pertussis, Chickenpox, Tuberculosis), If yes, please specify details in comments			
20	Did the student suffer from Viral Hepatitis?			
21	Did the student suffer from Poliomyelitis (Infantile paralysis infection)?			
22	Does the student suffer from any Mental or Behavioral Problem? If yes, please specify in comments			
23	Does the student suffer from any other Problem or disease not mentioned here? If yes, please specify in comments			

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

Medications or Treatments taken continuously

Medicine Name: ..... Dosage: .....

Emergency Medications

Medicine Name: ..... Dosage: .....

Any treating Doctor instructions on Student's nutrition

.....

Any treating Doctor instructions on Student's physical activity and exercise

.....

Any treating Doctor instructions for Student's School Doctor/Nurse to apply during the school day

.....

.....

Family Medical History

	Health Problem	Yes	No	Comments
1	Any Cardiovascular problem and Hypertension			
2	Diabetes			
3	Any Hereditary Blood Disease (e. g. Thalassemia, sickle cell anemia, Hemophilia)			
4	Any type of Cancer			
5	Any Immune System problem			
6	Any Mental Health problem			
7	Others, please specify in comments			

I agree for my child to have curative and/or preventive services that may include first aid, screening for height, weight, vision acuity, hearing test, dental checkup, Back examination scoliosis screening, Comprehensive Medical Examination, referral to emergency room when necessary, administer emergency medications when needed, and applying the Healthcare Management plan which is planned for based on the instructions of the treating doctor and parents.

Parent/ Guardian approval and verification for the above mentioned information

☐ **I certify that the above provided information are valid**

☐ **I agree for my child to be provided with the above mentioned health services according to the need**

☐ **I disagree for my child to be provided with the above mentioned health services (**In case of refusal, the above services will not to be offered except in emergency situations which require immediate intervention)

Parent /Guardian Name: ..... Relationship: .....

Parent/ Guardian Signature: ..... Date: .....

Notes

- **Please attach medical reports about the Student's health problem, if any**
- **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.**
- **This consent has to be filled each academic year and updated whenever required**

Please contact the School Doctor/Nurse if there are any queries

Delhi Private School Dubai

HEALTH INFORMATION

OVERVIEW OF POLICY

The school nurse maintains medical records for every child and requests parental help in keeping these records up to date. If your child has a persistent condition, allergies or any medical condition that the school should be aware of, please specify in detail the nature of the condition, the signs and symptoms and any medication that may need to be administered immediately.

MEDICAL CHECK-UP

The Department of Health and the school require that all students in the school have a general medical examination. Parents will be informed if their child requires any special medical attention**.**

POLICY ON ACCIDENT AND EMERGENCIES

School Nurse or School personnel shall notify the parents or guardians in the event of accidents and / or cases of emergencies.

POLICY ON MEDICATION

Medication will not be dispensed without written permission. If your child needs to take any medication during school hours, please ensure that this medication is stored in the School Clinic, with the nurse, and that it includes exact directions on administering the medicine including amount and frequency.

POLICY ON INFECTIOUS DISEASES

Children should not be sent to school if they are unwell. In the case of infectious diseases such as Chicken Pox, Conjunctivitis, Mumps etc., they should only return to school when the quarantine period ceases. No child will be allowed to attend school without a medical certificate or the school doctor's approval in the case of having contracted any infectious disease.

HEAD LICE

A check will be done if a case of head lice is reported in any particular class. Parents should not be offended, as this is a common condition amongst children, and can be easily treated. Your co-operation in administering treatment to your child if required would be highly appreciated.

MEDICAL DECLARATION

Please complete the four medical forms (**School *Health Record; Infection Control Policy; Medical Treatment-Paracetamol and Authorization for Emergency Treatment)*** and return them to the school Nurse as soon as possible once your child has started school.