STUDENT'S MEDICAL FORM

NAME OF STUDENT: _____ Grade Level: _____

Date of Birth: _____ Gender: _____

Blood Type: _____ Nationality: _____

Parent/s Contact Information:

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

Mobile Number: _____ Mobile Number: _____

Home Number: _____ Home Number: _____

Work Phone Number: _____ Work Phone Number: _____

A. Does your child have any allergy? YES ( ) NO ( )

If yes, please indicate the kind of allergen/s. _____

What medication/s does your child take in case of an allergic reaction? _____

B. Does your child have asthma? YES ( ) NO ( )
If yes, what medication does your child take in case of an asthma attack? _____

C. Does your child's immunization shots are updated? YES ( ) NO ( )
(Please attach copy of the immunization record.)

D. Does your child had history of any infectious disease? Please tick below.

	YES	NO		YES	NO
DIPHTHERIA			CHICKEN POX		
INFECTIOUS HEPATITIS			RUBELLA		
MEASLES			TUBERCULOSIS		
MUMPS			WHOOPING COUGH		
POLIOMYELITIS			SCARLET FEVER		

F. Does your child have any other medical conditions that the school needs to be aware of? YES ( ) NO ( )
If yes, please indicate below and attached a medical certificate indicating the medical diagnosis.

Other conditions: _____

G. In case of emergency please contact:

Name: _____ Relationship: _____

Mobile Number: _____

Please be informed that:

1. In the event, that your child is sick (fever, vomiting, loose motion), we will contact you to collect your child as soon as possible. Your child may stay in the clinic while waiting to be collected.
2. If your child is sick please, do not send your child to school, let him rest at home and inform their respective teachers and or the school nurse. A medical certificate, parent letter should be submitted to the nurse when your child will return to school to mark your child as excuse absent.
3. If any **prescription medication** (antibiotics, anti- viral etc.) will be given during school hours, kindly fill out a **consent for medicine administration form** provided in the clinic with the medicine properly labeled. **NO CONSENT, NO MEDICINE ADMINISTRATION**.
4. In the event, of an accident/ emergency and your child needs to be sent to the hospital for **urgent** treatment, we will immediately contact you but if in any effort that was made and you are unreachable your child will be sent to HAMAD HOSPITAL via ambulance accompanied by a school staff.

PARENT PERMISSION TO GIVE OVER-THE-COUNTER MEDICATION

( ) I give permission for medication(s) listed below to be given to my child for administration at the **Nurse's discretion or dispense by designated personnel as delegated by the school nurse.**

Please tick oral over the counter medicine/s that you allow your child to be administered in the school clinic.

( ) Paracetamol / Acetaminophen (Panadol Advance) – for pain, fever, period cramps
( ) Ibuprofen (Advil, Brufen) - for high fever, pain, swelling, period cramps
( ) Lozenge – for sore throat
( ) Antacid (Maalox) – for indigestion, gas pain
( ) Antispasmodic (Buscopan) – for stomach cramps, bladder spasm
( ) Anti diarrhea (Immodium) – for loose motion
( ) Antihistamine (Claritine, Zyrtec) –for allergic reaction
( ) Cold medications (Panadol Cold And Flu) – for congestion / colds

( ) I DO NOT ALLOW MY CHILD TO BE GIVEN ANY ORAL OVER THE COUNTER MEDICINE IN SCHOOL.

Parent's/ Guardian's Signature: _____ Date: _____

Revised: October 2018