

Public Health Protection Department- School Health Section

Student Medical Form

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 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ID Number: .....
Student's Passport Copy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Original Vaccination Card or Updated Copy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Health Card Copy (if any)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Health Card Number: .....
Health Insurance Card Copy (if any)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?			

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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	Does 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			

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**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			

**Parent/ Guardian approval and verification for the above mentioned information**

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.

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

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