



GEMS WELLINGTON مدرسة جيمس ولينجتون  
INTERNATIONAL SCHOOL انـــــــجـــــــرناـــــــل

# Medical and Immunization Record with Consent Declaration

## Confidential



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INTERNATIONAL SCHOOL انـــــــternational School

## MEDICAL & IMMUNISATION RECORD WITH CONSENT DECLARATION

**(Confidential)**

Dear Parents,

It is required by the Dubai Health Authority and by the school that all students must have their own school health records maintained in individual files within the school clinic. We are updating our health records and making fresh ones for students who are new in UAE. **Please complete all the pages of the attached Medical form** as this will enable the school medical team to have a better understanding of your child's general health condition. Please notify the school if your child is suffering from any **chronic medical condition or having any specific treatment**. If there is a change in his /her medication or a new medicine started for a recently diagnosed illness, please inform the school medical staff as early as possible.

Dubai Health authority requires that the school maintains current information of each child's immunization history. Kindly provide a **true photocopy of the original vaccination card** along with this form. If the vaccination card is in your regional language, you will have to provide a **translated copy in English** which is properly attested by your private doctor.

**Please sign the medical form in pen** (not in pencil) and provide a **recent passport size photograph** of your child. If your child has been in another school in Dubai prior to this school, you must write the name of the school on the attached letter.

**Please return the form to the school clinic in two days**. If you consider any other information necessary for your child's medical file, write on a separate paper and attach.

Kindly note that all consents are valid for the duration of time that your child stays in Gems Wellington International School.

Thank you for your attention.

**School Medical Team,**

**Gems Wellington International School.**

In the event that your child develops fever, pain, allergy or any other symptom or if he/she has injured himself /herself, it may be necessary to administer some medication. This is to authorize the School Doctor/ Nurse to administer the appropriate medicines for various situations. **The following are the**



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**First Aid Medications available in the sick bay.** Please tick **✓** the medicines below that can be administered to your child when necessary in school.

✓	S.No.	Name of the medicine	Indication
	1.	Claritin Tab/ Syrup Zyrtec	Common Cold or Allergy
	2.	Prospan Syrup	Cough
	3.	Strepsils / Vicks Lozenges	Sore throat
	4.	Panadol cold and flu tablet	Common cold and headache (only above 12 years of age)
	5.	Panadol Tab or Adol Syrup	Headache, fever or body ache
	6.	Adol Suppository	High fever (small children only)
	7.	Brufen Tab/ Syrup	Pain/ Inflammation /swelling
	8.	Buscopan Tab/ Scopinal Syrup	Abdominal pain/ cramps
	9.	Motilium Tab/ Syrup Dompy	Nausea and Vomiting
	10.	ORS powder with water	Dehydration
	11.	Rennie Chewable Tab	Dyspepsia & Heart Burn/gas pain
	12.	Voltaren Gel/ Reparil gel	Muscular Sprains and aches
	13.	Fucidin ointment	Minor and major wounds, skin infections etc
	14.	Fenistil Gel	Insect bites and itching
	15.	Flamazine cream/ Mebo	Burns
	16.	Medijel Gel	Mouth sores/ mouth ulcers
	17.	Bepanthen cream	Minor skin injuries, grazes (abrasions) etc.
	18.	Optrex Eye drops	Eye irritation, mild redness
	19.	Otrivin Nasal Drops	Blocked nose
	20.	Calamine lotion	Sun burns, itchy or irritated skin

OR

Please do not give my child any of the above medications

Comments: \_\_\_\_\_

Name of the Parent: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Name of Student: \_\_\_\_\_

#### ☑ CONSENT FOR EMERGENCY TREATMENT

The School Nurse/ Doctor/ Administrators will attempt to contact the parents should a medical emergency arise. They will do the needful according to the regulation from DHA (Dubai Health authority) and what is in the best interest of the health and well-being of the student. You may be required to come and collect the child from the school if possible or arrive at the informed hospital/ clinic to meet your child. An ambulance would be called if needed as per DHA guidelines.

In the event, parents cannot be contacted, I authorize and empower the GWIS Doctor/ Nurse to make any and all decisions concerning the medical or surgical care of the child which may include taking the child to an outside doctor or hospital for an emergency treatment.

Name of parent: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### CONSENT FOR ADMINISTRATION OF PARACETAMOL

In the event that your child develops fever or has pain it may be necessary to administer Paracetamol. If your child is unable to take this medication, please contact the School Nurse to discuss the use of an alternative. I consent to my child being given Paracetamol, should it be considered necessary by the School Nurse.

Name of the parent \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please note that if your child needs to take any of his/her personal medication during school hours for any acute or chronic condition (other than the medicines available at school), you will have to keep it in the school clinic with the school nurse in a well labelled container along with a prescription from his private doctor. It will be administered to your child only by the school nurse at the required time.

COMMENTS: \_\_\_\_\_

Name of the student: \_\_\_\_\_



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## ☑ CONSENT FOR MEDICAL EXAMINATION

The school medical examination is a screening procedure for students at certain age groups, aiming at detecting any abnormalities or defects which might need medical interventions. It will be conducted throughout the academic year by our licensed school doctor. The school nurse will help the school doctor in conducting the physical examination and will be present during the entire checkup. It will include screening almost all body systems and assessment of growth and development of the student. It will also include vision check using eye chart.

The height and weight will be checked for all students each year for the Body Mass Index graphs. Detailed medical checkup will be conducted at the following grade levels:

FS1                      Year 5  
Year 9                      Year 13                      and all new students in all Years (School entry).

Vision will also be checked at year 1 instead of FS1. The results of examinations will be documented in the school health record of your child. Any findings requiring additional follow ups or referrals will be reported to the parents.

If you have any queries or concerns regarding the examination, please contact the School Doctor/ Nurse.

I consent for the medical examination of my child by the school doctor at GWIS.

YES                      NO

If you do not consent to this, you will need to provide the school health office with a similar medical report from your private doctor (pediatrician / family physician).

Name of Parent: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## INFECTION CONTROL POLICY



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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:
  - A fever (Not to return to school for 24 hours after the last fever episode)
  - A skin rash (until the rash clears the contagious stage)
  - Persistent vomiting (not to return to school for 24 hours after the last vomiting episode)
  - Persistent diarrhea (not to return to school for 24 hours after the last diarrhea episode)
  - A persistent cough or sore throat
  - Heavy nasal discharge
  - Red, watery, sticky with discharge and painful eyes
  - Head lice
2. If he/she has an infected sore or wound, it must be covered by a well sealed dressing or plaster.
3. If your child is assessed by the school medical team and deemed to be a possible source of infection to other students and staff, you will be contacted to take them out of school immediately.
4. Please make sure that a proper medical treatment is taken and inform the school health office if your child is being treated for a medical condition.
5. Kindly make sure that your child practices hand hygiene, maintains short nails, clean clothes and clean hair etc.
6. Anyone infested with head lice will not be allowed in school until the hair is thoroughly treated and is free from lice. Every week please check your child for head lice or nits and if he/she is infested, start the treatment at home and report the same to the school nurse. It will be kept confidential.

I have read and understood the above infection control policy.

Name of the parent: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT FOR IMMUNIZATION





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Child Name: -----

Date of Birth: -----

School Name: -----

Class/Grade: -----

Please Tick (v)

I give the consent for the immunization of my child

I don't agree for immunization of my child.

Name & Signature: -----

Parents/ Guardian

P.O.Box:-----

Telephone Number: -----

Dear Parents




Please provide the following information to update your child school health record and send his/her ORIGINAL IMMUNIZATION CARD

**CHILD HISTORY OF ILLNESS:**

Please tick (v) appropriately, if yes, Specify Month/Year of illness



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Infectious Disease	YES	NO	Non-Infectious Disease	YES	NO
Diphtheria			Accidents		
Dysentery			Allergies		
Infective Hepatitis			Bronchial Asthma		
Measles			Congenital Heart Disease		
Mumps			Diabetes Mellitus		
Poliomyelitis			Epilepsy		
Rubella			G6PD (Glucose6-Phosphate Dehydrogenase deficiency)		
Scarlet Fever			Rheumatic Fever		
Tuberculosis			Surgical Operation		
Whooping Cough			Thalassemia		
Chicken Pox					

If yes, write the year of illness

History of:

Blood Transfusion No Yes, Frequency: -----

Hospitalization No Yes, Reason: -----Date:

family History: Diabetes- Hypertension- Mental Disorder- Stroke- Tuberculosis-

Other, Specify-----

Licensed School Nurse Signature: -----





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Letter for refused vaccination in the school premises

Student Name: .....

Date of Birth: .....

Class/Grade: .....

School Name: .....

I am Mr. / Mrs. .... (Father/Mother) of  
Student.....

This is to inform you that I have objection for my son/daughter to receive the vaccination in the  
school premises for the reason of

.....

**I agree & assure to provide the school with a copy of updated vaccination record in regular  
basis.**

Signature: .....

Date: .....

Telephone Number: .....



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