

# STUDENT'S MEDICAL CONSENT FORM & HEALTH RECORD

Please attach a  
picture of your  
child here

<b>Name of Student</b>	
<b>Class</b>	
<b>Date of joining Swiss International Scientific School – Dubai</b>	
<b>Date of filling record</b>	
<b>Name of previous school &amp; Location (city / country) of previous school</b>	

## Required Documents:

- Medical reports & prescriptions for any medical condition, long-term medications or continuous treatment.
- Copy of your child's original Vaccination Card/Record, updated & translated to English.

**Please fill this form and send it back to the Admissions Team or email it to [admissions@sisd.ae](mailto:admissions@sisd.ae).**

**Please note that all medical consents, policies and procedures are valid for the duration of the time your child attends SISD till graduation or departure/transfer.**

Please note that if your child commences any new medication, treatment or changes their existing medication, the school clinic must be informed.

The information provided will be treated as confidential.

If you have any queries, please feel free to contact the school clinic at [clinic@sisd.ae](mailto:clinic@sisd.ae).

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

## STUDENT'S INFORMATION

<b>Child's Name</b>	
<b>Date of Birth</b>	
<b>Gender</b>	
<b>Nationality</b>	
<b>Student's Emirates ID Number</b>	
<b>Significant Medical Information Allergies / Medical Conditions (in brief)</b>	

<b>Father's / Guardian's name</b>	
Father's mobile number	
Father's work number / other contact numbers	
Father's email address	
<b>Mother's / Guardian's name</b>	
Mother's mobile number	
Mother's work number / other contact numbers	
Mother's email address	
<b>Home telephone number(s)</b>	
<b>Emergency / alternative contact's name</b>	
Relationship to student	
Emergency / alternative contact's mobile number	
Emergency / alternative contact's email	
Does your child have any siblings in SISD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name(s) of sibling(s) and class	_____ _____ _____ _____

<b>Family Physician's name and contact number</b>	
<b>Family's preferred clinic or hospital</b>	
<b>Preferred hospital in cases of emergency</b>	
<b>Other Details</b>	_____ _____

## CLINIC FLOW PROCEDURE

The school clinic provides first aid only for illnesses and injuries that occur in school during school hours. **Any illness or injury occurring outside of school must be treated privately at home.**

1. If a student is ill or injured, he/she should be kept at home until he/she is deemed fit enough to return to school by their treating doctor. Please email the class teacher/grade coordinator and copy the clinic (health@sisd.ae or clinic@sisd.ae) and the department's secretary, explaining your child's reason for absence. A sick student will not be allowed back in school without a medical clearance certificate detailing that the child is fit to return to school.
2. If the student is not feeling well at school, then the student will inform the teacher who will then send the unwell student to the clinic. The child will be assessed by the clinic staff and first aid will be provided **according to the Clinic's regulations and protocols and the signed medical consent.**
3. Unwell students will be observed after treatment in the clinic. The student will be sent back to the class if deemed to be stable by the clinic team. **The decision to send a child back to class or home is done at the discretion and judgment of the clinic staff.**
4. **At the discretion of the clinic staff, parents will be contacted via their registered numbers, according to the Clinic's Communication Policy.** If one parent does not answer, the other will be contacted. They will be informed about the situation of their child and whether or not the student can go back to class or needs to go home or the hospital. Students may not contact their parents to collect them.
5. **Parents are required to pick up their children within 30 minutes** (in cases of suspicion of communicable diseases) **or within 1 hour** (for other illnesses or injuries) **after being informed to collect their children.**
6. Emergency cases that require immediate transfer to the emergency department will follow the Clinic's Accidents, Injuries and Medical Emergencies Procedure and Policy.
7. **Students whose parents have not submitted their medical consents cannot be treated in the school's clinic.** Only in cases of emergency will first aid be applied according to the Clinic's Accidents, Injuries and Medical Emergencies Procedure and Policy.
8. **Under no circumstances is a student permitted to leave the school because of illness unless arrangements for dismissal have been made through the clinic.** They have to be assessed by the clinic before they are released to their parents and excused from school.

*I have read and understood the above clinic flow procedure*

**Name of Parent**

**Signature**

## HEALTH INFORMATION, MEDICAL HISTORY & IMMUNIZATION RECORD

HEALTH CONDITIONS		YES	NO
1	Learning difficulties (e.g., ADHD, dyslexia)		
2	Mental disorders or behavioral problems (e.g., depression, anxiety, eating disorders, bed wetting, aggression, etc.)		
3	Allergies to drugs, food, dust, animal fur, medications, etc. Please specify the symptoms and whether severe or mild/moderate in the next page, needs to carry an EpiPen		
4	Asthma, bronchitis, breathing difficulties or pulmonary disorders		
5	Diabetes Mellitus type 1 or type 2		
6	Cardiovascular (heart), hypertension, or pulmonary (lung) disorders		
7	Epilepsy, seizure disorders or febrile convulsions		
8	Epistaxis (nose bleeding) or bleeding disorders (e.g., hemophilia, von Willebrand disease, etc.)		
9	Hemolytic or hereditary anemias or blood disorders (e.g., G6PD deficiency, thalassemia, sickle cell anemia, etc.)		
10	Wears glasses (e.g., myopia - nearsightedness, hyperopia - farsightedness)		
11	Vision difficulty or eye problems (e.g., diplopia, astigmatism, nystagmus, lazy eye, etc.)		
12	Hearing difficulty or ear disorders (hearing loss, recurrent otitis media, tympanostomy / ear tubes, etc.)		
13	Migraine, frequent headaches, or other neurological or brain disorders (e.g., hydrocephalus, tumors, head or spinal cord injury)		
14	History of infections: chicken pox, mumps, measles, rubella, diphtheria, pertussis (whooping cough), tuberculosis, poliomyelitis, scarlet fever, dysentery, infective hepatitis, other infectious diseases (details below)		
15	Liver disorders, viral hepatitis, renal (kidney) disorders or autoimmune disorders		
16	Connective tissue or skin disorders (e.g., eczema, dermatitis, acne, warts, etc.)		
17	Endocrine disorders like hypothyroidism or growth hormone deficiency		
18	History of treatment / therapy with psychologist, psychiatrist, or counsellor		
19	History of any previous hospitalizations, or history of accidents or fractures		
20	History of surgical operations or procedures, history of blood or blood-products transfusions, or history of use of any medical aid devices		
21	History of any other diseases or disorders, medicines or treatments taken continuously, or necessary emergency medicines		
22	History of specific instructions or restrictions from the treating physician or nutritionist regarding the diet or physical activity		
23	Family history of diabetes mellitus, hypertension, tuberculosis, stroke, mental disorders, others		

Please explain any **YES** responses to the above in more details, including signs and symptoms of the condition, treatment, medications and prevention of acute bouts in the following dedicated space. If you have any other concerns about your child, please mention them. Please continue on a separate sheet if necessary.

Kindly indicate below if your child has suffered from any of the following infections:

ILLNESS	IF YES, PLEASE INDICATE DATES	ILLNESS	IF YES, PLEASE INDICATE DATES
Chickenpox		Poliomyelitis	
Diphtheria		Rubella	
Dysentery		Scarlet Fever	
Infective Hepatitis		Tuberculosis	
Measles		Whooping Cough	
Mumps		Other infectious diseases	

## HEALTH INFORMATION, MEDICAL HISTORY &amp; IMMUNIZATION RECORD – continued

Kindly elaborate and attach/send reports for any medical condition or continuous treatment for your child.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Immunization Record:

- It is mandatory that the school maintains updated immunization history and information for every student. If your child is not immunized, kindly contact the clinic at [clinic@sisd.ae](mailto:clinic@sisd.ae).
- **Please attach a copy of your child's original vaccination card or record, updated & translated to English with this form.** It has to be provided in English transcript if it is in a language other than English or Arabic for clear understanding of the given vaccines.
- **Kindly be informed that the clinic retains only digital copies of the immunization card.**
- If you have lost/misplaced your child's card, kindly inform the clinic.

***I confirm that the above information is true and will update the clinic promptly in case there is a change in my child's health status. I have also read and understood the above guidelines, and I confirm that the vaccination record provided is a true copy of my child's vaccination card/record.***

**Name of Parent**

***Signature***

## CONSENT & PROCEDURE FOR EMERGENCY TREATMENT

- In the event that your child is very ill or requires additional emergency or medical treatment you will be contacted and asked to collect your child from school. Where advanced medical intervention is urgently required, your child will be taken to the emergency department / hospital for resuscitation and treatment.  
**This applies even if you are not reachable** and efforts to contact you will continue.
- Parents must understand that in cases of emergency, the school clinic team will disclose relevant medical information and the health record of the student to the EMTs / paramedics / healthcare providers to optimize the student's safety and health.

***I have read and understood the above procedure and understand that my child will be taken to hospital in the event of a severe injury, a medical emergency, or where advanced medical intervention is urgently required.***

**Name of Parent**

**Signature**

## CONSENT FOR HEALTH SCREENING & MEDICAL EXAMINATION

- According to authorities' directives and the school health guidelines, school children require a medical examination at certain key stages in their school lives. The basic annual health checkup is provided to targeted student age-groups in the school to monitor their health, growth and development. It consists of 3 components:
  - A mandatory Height and Weight / BMI measurement.**
    - This is a compulsory checkup for our students, conducted in various stages throughout the school year. The height and weight are measured, and the BMI is calculated.
  - A dental and vision screening among other screenings.**
    - This is organized by the DHA, and we'll let you know before hand when it is scheduled.
  - A Physical Examination with the school doctor.**
    - This is optional and parents have to provide their consent for this examination. It is a basic and non-invasive medical checkup that screens children for possible health problems. It is limited to select student groups in the school.
    - Parents who prefer to have their child examined by their own family physician or GP may do so at their own convenience. **The school will require a copy of the doctor's report to keep on file in the child's school health record.** Should parents change their minds and choose to provide or decline consent to this physical examination, we ask them to kindly send an email to clinic@sisd.ae with the child's name and explaining their preference.
- Parents will be notified of any findings requiring additional follow up or referrals, and they will be asked to take their child to the pediatrician / family physician for further follow up after school hours.



***I consent to my child to undergo physical examination with the school doctor***



***I refuse that my child will undergo physical examination with the school doctor***

**Name of Parent**

**Signature**

## INFECTION CONTROL POLICY – STAY AT HOME IF UNWELL

In order to reduce the spread of illness in the school, the following regulations apply:

- **DO NOT send your child to the school if they have:**
  - FEVER ABOVE 37.5°C
  - SIGNS AND SYMPTOMS OF INFLUENZA OR A FLU-LIKE ILLNESS
  - ACTIVE TONSILITIS OR PHARYNGITIS
  - RED, WATERY, PAINFUL OR STICKY (YELLOW DISCHARGE) EYES
  - SKIN RASH OF AN INFECTIVE OR UNKNOWN ORIGIN OR ON AN EXTENSIVE AREA OF THE BODY
  - VOMITING OR DIARRHEA (CONTINUOUS)
  - SIGNS & SYMPTOMS OF CHILDHOOD INFECTIOUS DISEASES (CHICKENPOX, MEASLES, MUMPS, ETC)
  - HEAD LICE
  - ALL CASES OF INFECTIVE/ COMMUNICABLE DISEASES UNTIL THE END OF THE COMMUNICABILITY PERIOD AND PROVISION OF A CLEARANCE CERTIFICATE
- If they have an infected or open sore or wound, it must be covered by a well-sealed dressing or plaster.
- **If your child is assessed by school clinic team and suspected to be ill or a possible source of infection to others, you will be contacted to pick them up from school within 30 minutes.**
- **A child with a suspected communicable or infective disease can only return to school after the relief of his/her symptoms and with a medical clearance from his/her pediatrician / treating physician.**
- All cases of infectious diseases should be away from the school for all periods of communicability. The child will be allowed to attend the school only with a medical certificate, stating that the child is not infectious anymore. (It is clearance certificate, not the certificate of absence).
- The siblings (if any) or household members of the child will be assessed as well to ensure they have not contracted the same communicable disease.
- Those students will be checked in the Clinic before the resumption of class.
- Please inform the school if your child has been or is being treated for a medical condition.
- The school clinic only provides first aid for illnesses and injuries that occur in school during school hours. Any illness or injury occurring outside of school must be treated privately at home.

***I have read and understood the above infection control policy***

***Name of Parent***

***Signature***

## CONSENT FOR ADMINISTRATION OF MEDICINES & PROCEDURE FOR MEDICATIONS

- Please mention or indicate if your child is allergic to any medications in the space previously provided for the health information and medical history (page 5).
- Please indicate your consent or refusal of administration of medicine to your child by choosing one of the options below.
- If none of the options are indicated or multiple boxes are ticked, it will be assumed by the clinic team that full consent was authorized.**
- As the parent/guardian of \_\_\_\_\_  
(child's full name and date of birth), and in case of injury or illness, I (please select one of the following options with a tick):

☐

- my authorization and consent for any medical care for my child, including the administration of the necessary and appropriate medications for various situations or cases, deemed necessary and provided the school's clinic team.

OR

☐

- Give permission to deliver healthcare to my child, with the EXCEPTION to some medications identified below **Please, mark with a cross, the medication that you refuse to be given to your child**

	MEDICINE	INDICATIONS	MARK HERE
1	Paracetamol (Panadol / Adol) Syrup / Tablet	Fever, mild pain	
2	Ibuprofen (Brufen / Advil) Syrup / Tablet	Fever, pain	
3	Antihistamines (Aerius/ Claritine/ Zyrtec) Syrup / Tablet	Allergy, congestion, cold symptoms	
4	Hyoscine (Scopinal / Buscopan/ Hycom) Syrup / Tablet	Abdominal colic	
5	Domperidone (Dompy / Motilium) Syrup / Tablet	Nausea, vomiting	
6	Kaptin / Imodium (Loperamide) Syrup / Tablet	Extensive diarrhea	
7	Rennie / Gaviscon / Maalox Chewable Tablets	Indigestion, heartburn	
8	Opticrom / Optifresh / Croma Eye Drops	Allergic conjunctivitis (eye allergies)	
9	Allergan Refresh Plus / Optrex Eye Lotion	Lubricant, eye wash	
10	Fenistil (Dimetindene) Gel	Insect bites and allergy	
11	Calamine lotion	Rashes, itching	
12	Fucidin Cream	Cuts and wounds	
13	Savoy Antiseptic Spray	Cuts, abrasions, burns, scalds	
14	Voltaren (Diclofenac) Gel	Pain, bruises	
15	Silvadiazine Cream	Burns	
16	Reparil / Arnica gel	Bruises, swelling	
17	Medijel (Aminoacridine & Lidocaine) Gel	Mouth ulcers	
18	Dentinox Teething Gel	Tooth pain	
19	Deep Freeze spray / Deep Heat spray or gel (> 5 Years)	Muscular pain and sprains	
22	Nebulization with Normal Saline (salt water) only	Respiratory irritation or distress	
23	Nebulization with Salbutamol (Albuterol / Ventolin)	Respiratory distress	
24	Cough syrup (Prospan / Zecuf / Mucosulvan)	Persistent irritating cough	
25	Vaseline cream / Aloe Vera gel / Bepanthen moisturizing cream	Dry lips / skin	
26	Lozenges (Zecuf / Strepsils) (> 6 years)	Sore throat	
27	ORS Oral Resuscitation Salt	Dehydration	
28	Activated Charcoal tablet	Excessive gases and bloating	

OR

☐

- Refusal of Treatment: Refuse any kind of medical care for my child by the clinic team. I am aware that by choosing this option, I am releasing the clinic team and Swiss International School of Dubai of any liability or medical claims resulting from my decision to refuse care against medical advice. I also understand that my choice and signature on this refusal make me completely responsible for any complications that may happen to my child. I also understand in cases of critical or major emergency (life threatening or disabling emergencies), the clinic team will follow their emergency protocol to save and protect my child's life.



## CONSENT FOR ADMINISTRATION OF MEDICINES & PROCEDURE FOR MEDICATIONS – continued

- Please note that tablets are administered only to older children who can swallow.
- If you would like to change your consent, please email us at [clinic@sisd.ae](mailto:clinic@sisd.ae).
- The following is the **Procedure for Medications** which provides general guidelines to parents regarding administration of medications prescribed by their private medical advisors. Sometimes it may be necessary to administer medicine during the school hours even though the child feels well but needs to complete a prescribed course of medicine.
  1. For children with chronic illnesses such as allergies, asthma, epilepsy or diabetes, or any other chronic disease; a spare of emergency medications for the school (such as EpiPen, Inhalers, Diazepam, Insulin, Glucagon) should be provided by the parents.
  2. Students needing EpiPens will always need 1 EpiPen with them; in their bags or class, and 1 to be kept in the clinic.
  3. Any medication that a child needs to take during school hours should be handed over by the parents/guardians to the clinic team. Medications can be collected at the end of the school day or at the end of the prescribed course.
  4. **No medicine should be sent in the child's bag.**
  5. Where a child travels to school by the school transport, medications can be handed over to the Transport Assistant with the signed Authorization form and the copy of prescription.
  6. The medication should be carefully labeled with the student's name, route of administration and a required dose. It will be stored in the clinic. This then can be given in an emergency situation with prior written consent from the parent.
  7. Medications that are dosed twice daily should be administered by parents at home in the morning and after the school hours.
  8. If a child needs a prescription only medicine to be administered during school hours, a doctor's prescription needs to be obtained.
  9. **Parents will be required to give written consent in a Medical Authorization Form available in the school clinic for the administration of specified medication.**
  10. Medications must be sent in their original packaging and should be clearly labeled with the student's name, required dose, timing and route of administration. If a medication has been administered in the morning, a note should be sent to the clinic. Medication that needs to be refrigerated at all times must be transported with an ice pack rather than the ice-cubes.

***I have read and understood the above procedure guidelines.***

***I also confirm the above information and consent and will update the clinic promptly in case there is a change in my decision or in my child's health status.***

**Name of Parent**

**Signature**