Abdulaziz
International Schools
Al-Sulaimaniah

MEDICAL FORM

First Name: ____________________

Father's Name: ____________________

Family Name: ____________________

Date of Birth: ____________________

Grade: ____________________

1- Does your child currently take any medication?

Yes ◯ No ◯

If yes, please specify: why, dose and frequency ____________________

2- Has your child ever been hospitalised?

Yes ◯ No ◯

If yes, please specify, when and what for? ____________________

3- Is there a history of colour blindness in your family or any other visual problems?

Yes ◯ No ◯

If yes, please explain ____________________

4- Does your child have speech problems?

Yes ◯ No ◯

If yes, please explain ____________________

5- Does your child have difficulty in hearing?

Yes ◯ No ◯

If yes, please explain ____________________

6- Do you have any objection to the school doctor/nurse examining your child?

Yes ◯ No ◯

7- Does your child suffer from any medical problems?

Yes ◯ No ◯

If yes, please explain ____________________

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8- Does your child suffer from any of the following conditions?

Medical condition		Yes	No	Medication
Asthma	الربو الصدري			
Diabetes	السكري			
Epilepsy	داء الصرع			
Hay fever	الحساسية الربيعية الحمى الربيعية			
Tuberculosis	السلّ			
Eczema	الحكة			
Heart Disease	أمراض القلب			

9- Does your child have an allergy history?

Allergen

Eggs	Peanuts	Sea food	Wheat	Insects
Latex	Medication	Dairy Products	Fruits	Others

Please specify ______________________________

Reaction

Eczema	Rash	Hives	Eye swelling	Hoarse voice
Mouth swelling	Wheezing	Vomiting/diarrhea	Passed out	Others

Please specify ______________________________

Intervention needed

None	ER visit	Medication	Hospitalization	Others

Please specify ______________________________

In case of accidents or other emergencies – give three sources to be contacted

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If these sources cannot be contacted the student will be taken to the nearest hospital

10- **Has your child had any of the following inoculations?**
If yes, please fill in the date of the last vaccine.

Vaccine	Date of last taken vaccine
MMR (measles, mumps, rubella) (حصبة المانية، ابو كعب) حصبة	/ /
DPT (diphtheria, tetanus, pertussis) ثلاثي خانوق، شاهوق، كزاز	/ /
Hepatitis A التهاب الكبد الوبائي A	/ /
Hepatitis B التهاب الكبد الوبائي B	/ /
Polio شلل الأطفال	/ /
BCG السلّ (الدرن)	/ /
DT (diphtheria, tetanus) الخانوق، الكزاز	/ /
HIB (haemophilus influenza) هيموفيلوس انفلوانزا ـ السحايا	/ /
Meningitis السحايا	/ /
Typhoid التيفوئيد	/ /
Chicken Pox جدري الماء	/ /
Other: please specify	

11- Has your child suffered from any of the following illnesses?

Disease	Yes	No	Year
Measles الحصبة			
Mumps أبو كعب			
German Measles الحصبة الألمانية			
Chicken Pox جدري الماء			
Tuberculosis السلّ			
Whooping Cough السعال الديكي			
Other (Please State)			

If your child is to be administered a medication from your doctor during school hours, it will be given to the school nurse first thing in the morning with an accompanying letter from the parents or doctor. It can be then collected from the clinic by the student before going home. Please clearly write the child's name, class, time and dose of the medication. Medicines are not to be kept with children.

I Mr./Mrs ______________________, parent of the student ______________________, hereby certify that the information provided in this form is true and assume responsibility for any missing health-related information (illness and/or allergy), and I shall be responsible for and shall release and indemnify Abdulaziz International School, its employees, from and against all liability arising from all illnesses or allergies my child has, and the consequences that might result.

I understand that any false or misleading information or significant omissions may entitle the school to reconsider my child's attendance at school.
I agree to immediately notify the school should any illnesses develop.

في حال كان على الطالب أن يتناول دواءً خلال ساعات الدوام المدرسي، فيتوجب عليه إعطاء الدواء إلى طبيبة المدرسة صباحاً مع إرفاق رسالة من ولي أمر الطالب أو من طبيبه، ويتم أخذ الدواء من العيادة قبل مغادرة الطالب إلى المنزل من قبل الطالب.

يرجى كتابة إسم الطالب وصفه بشكل واضح وتدوين وقت أخذ الدواء والجرعة المحددة.

يمنع ترك الأدوية مع الطالب.

أنا الموقع أدناه ولي أمر الطالب / الطالبة ______________________

◯ أوافق ◯ لا أوافق على إرسال ابني / ابنتي في الصف ______________________
إلى المستشفى إذا حصل طارئ له / لها لا سمح الله.

Name ______________________ الاسم

Date ______________________ التاريخ

Signature ______________________ التوقيع

For School Use.

Remark ______________________

Date checked: ___/___/______ **Dr. / Nurse Signature:** ______________________