

Family Name <input type="text"/>	First Name <input type="text"/>	Middle Name(s) <input type="text"/>
Male/Female <input type="text"/>	Date of Birth (d/m/y) <input type="text"/> <input type="text"/> <input type="text"/>	Blood Group <input type="text"/>
Health Insurance (type of coverage and name of provider) <input type="text"/>	<input type="text"/>	Nationality <input type="text"/>
Name of Family Doctor <input type="text"/>	Contact Number of Family Doctor <input type="text"/>	

Please tick and give appropriate date if your child has had any of the following:

Contagious Diseases		Date	Date
1. Chicken pox	<input type="checkbox"/>		8. Scarlet fever <input type="checkbox"/>
2. Whooping cough	<input type="checkbox"/>		9. Tuberculosis <input type="checkbox"/>
3. German measles (rubella)	<input type="checkbox"/>		10. Pneumonia <input type="checkbox"/>
4. 7-day measles (rubeola)	<input type="checkbox"/>		11. Poliomyelitis <input type="checkbox"/>
5. Mumps	<input type="checkbox"/>		12. Meningitis <input type="checkbox"/>
6. Diphtheria	<input type="checkbox"/>		13. Scabies <input type="checkbox"/>
7. Hepatitis	<input type="checkbox"/>		14. Parasites <input type="checkbox"/>

Health Problems		Date	Date
1. Rheumatic fever	<input type="checkbox"/>		12. Speech difficulty <input type="checkbox"/>
2. Frequent ear infections	<input type="checkbox"/>		13. Operations <input type="checkbox"/>
3. Frequent colds	<input type="checkbox"/>		14. Serious injuries <input type="checkbox"/>
4. Tonsillitis	<input type="checkbox"/>		15. Concentration difficulties <input type="checkbox"/>
5. Diabetes	<input type="checkbox"/>		16. Headaches <input type="checkbox"/>
6. Epilepsy	<input type="checkbox"/>		17. Eyeglasses <input type="checkbox"/>
7. Heart disease	<input type="checkbox"/>		18. Wears contacts <input type="checkbox"/>
8. Fainting	<input type="checkbox"/>		19. Epistaxis (nose bleed) <input type="checkbox"/>
9. Asthma	<input type="checkbox"/>		20. Hereditary blood disorders <input type="checkbox"/>
10. Hearing difficulty	<input type="checkbox"/>		21. Kidney disease <input type="checkbox"/>
11. Vision difficulty	<input type="checkbox"/>		22. Spinal disorders <input type="checkbox"/>

Others (please specify)

Has your child received all required vaccinations? Yes No

For Office Use only:

Entry Grade:	<input type="text"/>
--------------	----------------------

Allergies

Please specify if your child suffers from any Food, Medication or other Allergies

Please describe and indicate the treatment required for any life-threatening allergic reactions suffered by your child:

Has your child been prescribed an Epi Pen? Yes No If yes, your child must either carry their Epi-Pen and inhaler if able and responsible to use them independently or keep them at the Health Centre in a supervised emergency medication cupboard.

Has your child been prescribed an inhaler? Yes No

Is your child taking medication now or periodically? If yes, please provide details:

Is there any reason for your child to have restricted physical activity? If yes, please provide details:

Please attach copies of all immunisations received, if available.

Consent for Health Centre Services Section

By signing this form, it indicates your consent for your child to use the first aid and health promotion services conducted at this school. These include:

1. Permission for the nurse to assess and administer initial first aid and use:

- Antiseptic cream and band aids for minor grazes,
 - Cool packs, herbal warm packs and pain relieving sports gel and bandages for minor muscle trauma,
 - Lozenges or throat spray for a sore throat,
 - Antihistamine gel for small bites or rashes,
 - Non medicated eye drops or eye flush for a minor eye irritation,
 - Gum and tooth pain relieving gel.
- For all oral or topical, or other medications including paracetamol, you will be contacted on a case by case basis.

2. Participation in the Health Authority of Abu Dhabi Health Screening Program

This school is mandated to conduct health and medical assessments at key stages in your child's development. These include height, weight, body mass index average, scoliosis, vision and hearing tests. As parents, you will be notified prior to any required examinations and also provided with the results (which will also be kept on a database by the Health Authority of Abu Dhabi). If you prefer, you can always arrange your child's own screening with a health provider of your choice and forward us the results.

3. Emergency Ambulance Transportation

If in the unlikely event your child requires hospitalisation, every effort will be made to contact you on the telephone numbers provided. If for some reason we are unable to contact you, we will utilise an ambulance service to either Al Noor Hospital, Mafraq Hospital or the nearest hospital.

- You may choose to decline any or all of these services however, the school will require a signed statement by you to keep your child's case notes.
- We would also like to reassure parents that the health, safety and wellbeing of the children are of prime importance to us at all times.
- Please note that this consent is valid for the duration of time that your child attends Raha International School.

I hereby confirm that all the above medical information is true and correct to the best of my knowledge:

Signature of Parent / Guardian

Date