COLLEGIATE AMERICAN SCHOOL

MEDICAL AND IMMUNIZATION RECORD
& Consent Declaration

CONFIDENTIAL

Student's name: _____Grade_____

Please complete and return prior to your child starting at CAS

COLLEGIATE AMERICAN SCHOOL

HEALTH INFORMATION

OVERVIEW OF POLICY

The school nurse maintains medical records for every child and requests parental help in keeping these records up to date. If your child has a persistent condition, allergies or any medical condition that the school should be aware of, please specify in detail the nature of the condition, the signs and symptoms and any medication that may need to be administered immediately.

MEDICAL CHECK-UP The Department of Health and the school require that students grades: KG1, 1, 5, 9 , 12 and all new students have a general medical examination and all students have their Body Mass Index (BMI) checked. Parents will be informed if their child requires any special medical attention**.**

POLICY ON ACCIDENTS AND EMERGENCIES

School Nurse or School personnel shall notify the parents or guardians in the event of accidents and / or cases of emergencies.

POLICY ON MEDICATION

Medication will not be dispensed without written permission. If your child needs to take any medication during school hours, please ensure that this medication is stored in the School Clinic, with the nurse, and that it includes exact directions on administering the medicine including amount and frequency.

POLICY ON IMMUNIZATION

CAS will be providing immunization for students under the umbrella of Dubai health authority. School vaccination starts from the age of 6 years (grade 1). The vaccines available are oral polio, DT, Td and MMR.

POLICY ON INFECTIOUS DISEASES

Children should not be sent to school if they are unwell. In the case of infectious diseases such as Chicken Pox, Conjunctivitis, Mumps etc., they should only return to school when the quarantine period ceases. No child will be allowed to attend school without a medical certificate or the school doctor's approval in the case of having contracted any infectious disease.

HEAD LICE

A check will be done if a case of head lice is reported in any particular class and a letter sent to the parents. Head Lice is a common condition amongst children, and can be easily treated.

MEDICAL DECLARATION

Please complete the four medical forms (**School *Health Record; Infection Control Policy; Immunization policy; Medical Treatment-Paracetamol and Authorization for Emergency Treatment)*** and return them to the school Nurse as soon as possible once your child has started school.

COLLEGIATE AMERICAN SCHOOL

SCHOOL HEALTH RECORD

In order to complete your child's CAS Medical Record please provide the following details:

Student's Name ----------

Heath Card No ---------- Male ☐ Female ☐

Nationality ---------- Date of Birth ---------- (dd/mm/yy)

Mother's Name ---------- Mother's Tel No ----------

Father's Name ---------- Father's Tel No ----------

Residence Tel No ---------- Fax No/ Email ----------

1. Does your child have any known medical problem or disability? Yes ☐ No ☐
2. Does your child wear glasses or contact lenses? Yes ☐ No ☐
3. Does your child have any hearing difficulties? Yes ☐ No ☐
4. Does your child take any medication other than vitamins? Yes ☐ No ☐
5. Does your child have any allergies? Yes ☐ No ☐

If you have answered YES to any of the above, please provide further details and indicate clearly whether this condition will, in your opinion, affect your child's ability to participate in any aspect of school life, EG regular classes, sport classes, field trips, after school activities etc.

Signs and Symptoms: ----------

Medication taken to prevent further reaction: ----------

Other information: ----------

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6. Previous school in Dubai (if one attended): ----------
7. Consent given for medical examination by School Doctor or Nurse Yes ☐ No ☐

Please provide:

8. One Passport –sized photograph of your child.
9. **Copy of vaccination records for our file.**

CONSENT FOR IMMUNIZATION

Child Name: ----------
Date of Birth: ----------
School Name: ----------
Class/Grade: ----------

Please Tick (√)
☐ 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 (√) appropriately, if yes, Specify Month/Year of illness

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-Phospate 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: ----------

هـيئـة الصحـة بدبـي
DUBAI HEALTH AUTHORITY

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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CONSENT FOR EMERGENCY TREATMENT

In the event that my child requires emergency treatment, I will be contacted and asked to collect my child from the school.

If the school is unable to contact me or the Emergency Contact Person, my child will be taken to Rashid Hospital (Dubai Government Hospital) accompanied by the School Nurse, for diagnosis and treatment.
Efforts to contact me will continue.

I consent to my child being taken to Rashid Hospital in the event of a medical emergency.

Name of Parent: ----------Signature: ---------- Date: ------

COLLEGIATE AMERICAN SCHOOL INFECTION CONTROL POLICY

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:
   - Fever
   - Skin rash
   - Vomiting (not to return to School for 24 hours after the last vomiting episode)
   - Diarrhoea (not to return to School for 24 hours after the last diarrhoea episode)
   - Persistent cough
   - Heavy nasal discharge
   - Red, watery and painful eyes

2. An infected sore or wound must be covered by a well-sealed dressing or plaster.
3. If your child is assessed by the School Doctor and/or School Nurse, and deemed to be a possible source of infection to other students, you will be contacted to take the child home immediately.

Please inform the School if your child has been or is being treated for a medical condition.

I have read and understand the above Infection Control Policy.

Name of parent: ----------Signature: ---------- Date: ----------

COLLEGIATE AMERICAN SCHOOL

CONSENT FOR MEDICINES ADMINISTRATION

Student's Name ---------- Grade ---------- Section ----------

I ***consent / do not consent*** to my child being given any of the following medicines, should it be considered necessary by the school doctor or nurse.

If your child is unable to take this medication, please contact the school doctor or school nurse to discuss the use of an alternative medication.

The medical staff will contact you if there are any concerns.

Name of drug	Age	Dose	Indication	Remarks
PARACETAMOL	All	15mg/kg/ dose	Pain, Fever	Repeat after 4 - 6 hours
Claritine Syrup	2-5 years: Above 6 years:	5ml 10ml	Allergy, insect bite	Every 12 hours
Fenistil Gel	All	-	Allergy, Insect bite	Every 8 hours
Brufen/Advil	All	5 mg /kg	Pain, Fever	Repeat after 8 hours
Maalox Plus Syrup	2-5 years; 6-18 years;	5ml 5-10ml	Nausea, Indigestion	Repeated after 2 hours
Scopinal syrup	6-18 years	10ml	Abdominal pain	Repeat after 6 hours
Saline Nasal Spray/ Drop	All	1 Puff/ Drop in each Nostril	Blocked nose	As required
Reparil Gel	All	-	Muscular trauma/swelling	Once daily
Optrex Eye Wash	As per instructions	Sand/ Dirt in Eyes	-	As required

Name of the parent: ..... Signature .....

Date .....