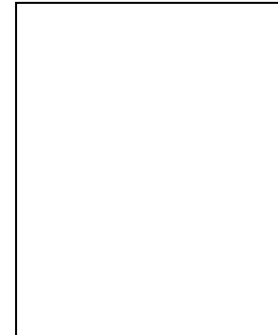


## Formblatt für die Krankenakte/*Document of medical record*

### Kind/*Child*

Vorname/ <i>Name</i>	
Familiennamen/ <i>Surname</i>	
Geburtsdatum/ <i>Date of birth</i>	
Staatsangehörigkeit/ <i>Nationality</i>	
Telefon Nummer/ <i>Telephone number</i>	
Notfall-Telefon/ <i>Emergency telephone</i>	
Name des Erziehungsberechtigten/ <i>Name of the parent/guardian</i>	



Passbild / Passport photo

### **EINVERSTÄNDISERKLÄRUNG/PARENTAL CONSENT**

Als Erziehungsberechtigter von ....., gebe ich mein Einverständnis für:

*As the parent/guardian of ....., I give my consent to the following:*

### **Einverständnis zur Verabreichung nicht verschreibungspflichtiger Medikamente** *Medication administration consent*

Da bei Kindern spontan Fieber auftreten kann, sie sich stoßen, Unfälle passieren oder sie Abschürfungen oder Mückenstiche erleiden, verfügt die Krankenschwester über eine Auswahl nicht verschreibungspflichtiger Medikamente. Im Falle schwererer Krankheiten (Übelkeit, Erbrechen, Durchfall etc.) als auch in den vorgenannten Fällen werden Sie von der Schule informiert, bevor ein Medikament verabreicht werden darf. Für den Fall, dass die Schule Sie nicht erreichen kann, benötigt sie im Vorfeld Ihr schriftliches Einverständnis zur oralen Verabreichung nicht verschreibungspflichtiger Medikamente.

*As children sometimes become ill, have an accident or scratches, bumps, mosquito bites, fever etc. the school has a supply of non-prescription medicines available. In case of severe illness (vomiting, diarrhea etc.) or prior to giving any oral medication, you will be contacted anyway. Please note that in case the school cannot reach you, we need your written permission for oral medication in advance.*

Ich stimme einer Verabreichung nicht verschreibungspflichtiger oraler Medikamente gegen Fieber, Schmerz oder kleineren Wunden zu. *I agree to my my child receiving an over the counter medication for fever, pain, sores and minor ailments if needed:*

Ja/*Yes*       Nein/*No*

 Unterschrift/*Signature*.....

Datum/*Date*:.....

**Notfallbehandlung**  
*Emergency Treatment*

Sollte ein Notfall eintreten, werden Sie von der Schule kontaktiert und gebeten, Ihr Kind abzuholen. Sofern die Schule Sie nicht erreichen kann, wird Ihr Kind für eine Diagnose und zur notwendigen Behandlung zum Arzt/Krankenhaus gebracht. Im Falle eines ernsthaften Notfalls wird seitens der Schule unverzüglich der Krankenwagen gerufen. Gleichzeitig wird die Schule weiterhin versuchen, Sie zu erreichen. Ich bin einverstanden, dass mein Kind in einem medizinischen Notfall zu einem Arzt oder Krankenhaus gebracht wird. Ich werde die anfallenden Arztkosten vollständig übernehmen.

*In the event that your child requires emergency treatment you will be contacted and asked to collect your child from the school. If the school is unable to contact you, your child will be taken to a doctor/hospital for diagnosis and treatment. In the event of a serious emergency, an ambulance will be called immediately. Efforts to contact you will continue. I agree to my child being taken to a doctor/hospital in the event of a medical emergency. I will be responsible for any arising medical costs/expenses.*

**Folgebehandlung**  
*Subsequent Treatment*

Sollte nach der Erstversorgung eine Folgebehandlung aufgrund einer Verletzung oder Erkrankung notwendig sein, so liegt die alleinige Verantwortung dafür bei den Erziehungsberechtigten des Kindes.

*If, following the initial treatment, a subsequent treatment due to an injury or illness is necessary, then the sole responsibility lies with the parent or legal guardian of the child.*

Unterschrift/*Signature*..... Datum/*Date*:.....

**Impfungen**  
*Vaccinations*

- Ich bin damit einverstanden, dass mein Kind geimpft wird.  
*I give the consent for my child to be vaccinated.*
- Ich bin aus folgendem Grund nicht damit einverstanden, dass mein Kind geimpft wird:  
*I do not agree with the vaccination of my child for the reason of:*

.....

*Ich bin damit einverstanden und versichere, dass ich der Schule in regelmäßigen Abständen eine aktuelle Kopie des Impfpasses zur Verfügung stelle*  
*I agree and assure to provide the school with a copy of updated vaccination record in regular basis.*

Unterschrift/*Signature*..... Datum/*Date*:.....



Bitte füllen Sie auch die folgenden im Anhang beigefügte verpflichtende Form der Dubai Health Authority aus. *Please also complete the following mandatory form of the Dubai Health Authority attached in the Appendix.*

1. School Immunization Consent Form

Public Health Protection Department- School Health Section

Student Medical Form

Student  
Photo

Dear Parent/ Guardian of the Student:

Please fill the following form accurately to ensure maintaining and monitoring your child's health and wellbeing during the school year

School Information	
School Name: .....	Grade: ..... Section: .....
Student Information	
Student Full Name: .....	Gender: .....
Date of Birth: .....	Nationality: .....
Parent or Legal Guardian Name: .....	Relationship: .....
Mobile Number (1): .....	Mobile Number (2): .....
E-Mail: .....	Emirate: .....
In case of Emergency and we are unable to reach the parent/guardian, the following person can be contacted:	
Name: .....	Relationship: ..... Mobile Number: .....

Required Attachments			
Student's Emirates ID Copy	<input type="radio"/> Yes	<input type="radio"/> No	ID Number: .....
Student's Passport Copy	<input checked="" type="radio"/> Yes	<input type="radio"/> No	
Original Vaccination Card or Updated Copy	<input type="radio"/> Yes	<input checked="" type="radio"/> No	
Health Card Copy (if any)	<input checked="" type="radio"/> Yes	<input type="radio"/> No	Health Card Number: .....
Health Insurance Card Copy (if any)	<input type="radio"/> Yes	<input type="radio"/> No	

Student Medical History			
Health Problem	Yes	No	Comments
1 Does the student suffer from any allergy to medicine, food, dust, etc? If yes, please specify in comments	<input type="radio"/>	<input type="radio"/>	
2 Does the student suffer from any Cardiovascular problem?	<input type="radio"/>	<input type="radio"/>	
3 Does the student suffer from Diabetes?	<input type="radio"/>	<input type="radio"/>	
4 Does the student suffer from Hypertension?	<input type="radio"/>	<input type="radio"/>	
5 Does the student suffer from Bronchial Asthma?	<input type="radio"/>	<input type="radio"/>	

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**Public Health Protection Department- School Health Section**

**Student Medical Form**

6	Does the student suffer from any Renal Problem?	<input type="radio"/>	<input type="radio"/>	
7	Does the student suffer from Epilepsy or Convulsion seizures?	<input type="radio"/>	<input type="radio"/>	
8	Does the student suffer from Epistaxis?	<input type="radio"/>	<input type="radio"/>	
9	Does the student suffer from Hemolytic Anemia, type G6PD?	<input type="radio"/>	<input type="radio"/>	
10	Does the student suffer from any Hereditary Blood Disease (e.g. Thalassemia, sickle cell anemia, Hemophilia)? If yes, please specify in comments	<input type="radio"/>	<input type="radio"/>	
11	Does the student suffer from any Skin Problem?	<input type="radio"/>	<input type="radio"/>	
12	Does the student suffer from any Eye problem (Myopia, Hyperopia...)? If yes, please specify in comments	<input type="radio"/>	<input type="radio"/>	
13	Does the student suffer from any Hearing problem?	<input type="radio"/>	<input type="radio"/>	
14	Does the student use any medical aid device? If yes, please specify the device details in comments	<input type="radio"/>	<input type="radio"/>	
15	Did the student undergo any surgery in the past? If yes, please specify the details in comments	<input type="radio"/>	<input type="radio"/>	
16	Was the student ever hospitalized? If yes, please specify the reasons in comments	<input type="radio"/>	<input type="radio"/>	
17	Does the student have any health condition that could weaken the immune system such as Cancer (Blood cancer, Lymphoma), or an organ transplant? If yes, please specify in comments	<input type="radio"/>	<input type="radio"/>	
18	Did the student get any blood, antibodies or plasma transfusion in the past?	<input type="radio"/>	<input type="radio"/>	
19	Did the student suffer from any of the following diseases: (Mumps, Measles, Diphtheria, Pertussis, Chickenpox, Tuberculosis), If yes, please specify details in comments	<input type="radio"/>	<input type="radio"/>	
20	Did the student suffer from Viral Hepatitis?	<input type="radio"/>	<input type="radio"/>	
21	Did the student suffer from Poliomyelitis (Infantile paralysis infection)?	<input type="radio"/>	<input type="radio"/>	
22	Does the student suffer from any Mental or Behavioral Problem? If yes, please specify in comments	<input type="radio"/>	<input type="radio"/>	
23	Does the student suffer from any other Problem or disease not mentioned here? If yes, please specify in comments	<input type="radio"/>	<input type="radio"/>	

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Public Health Protection Department- School Health Section

Student Medical Form

If the student suffer/suffered from any of the health problems mentioned or not mentioned above, please answer the following questions

**Medications or Treatments taken continuously**  
Medicine Name: ..... Dosage: .....

**Emergency Medications**  
Medicine Name: ..... Dosage: .....

**Any treating Doctor instructions on Student's nutrition**  
.....

**Any treating Doctor instructions on Student's physical activity and exercise**  
.....

**Any treating Doctor instructions for Student's School Doctor/Nurse to apply during the school day**  
.....

**Family Medical History**

	Health Problem	Yes	No	Comments
1	Any Cardiovascular problem and Hypertension	<input type="radio"/>	<input type="radio"/>	
2	Diabetes	<input type="radio"/>	<input type="radio"/>	
3	Any Hereditary Blood Disease (e. g. Thalassaemia, sickle cell anemia, Hemophilia)	<input type="radio"/>	<input type="radio"/>	
4	Any type of Cancer	<input type="radio"/>	<input type="radio"/>	
5	Any Immune System problem	<input type="radio"/>	<input type="radio"/>	
6	Any Mental Health problem	<input type="radio"/>	<input type="radio"/>	
7	Others, please specify in comments	<input type="radio"/>	<input type="radio"/>	

**Parent/ Guardian approval and verification for the above mentioned information**  
Parent /Guardian Name: ..... Relationship: .....

Parent/ Guardian Signature: ..... Date: .....

**Notes**

- Please attach medical reports about the Student's health problem, if any
- It is the responsibility of the Student's Parent/ Guardian to inform the school clinic of any changes in the Student's health status and submit medical reports accordingly to update the Student's Medical Record at School.

Please contact the School Doctor/Nurse if there are any queries

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