GERMAN INTERNATIONAL SCHOOL DUBAI
DEUTSCHE INTERNATIONALE SCHULE DUBAI

Formblatt für die Krankenakte/*Document of medical record*

Kind/*Child*

Vorname/*Name*	
Familienname/*Surname*	
Geburtsdatum/*Date of birth*	
Staatsangehörigkeit/*Nationality*	
Telefon Nummer/ *Telephone number*	
Notfall-Telefon/*Emergency telephone*	
Name des Erziehungsberechtigten/*Name of the parent/guardian*	

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 verabreichet 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:*…………………………

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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

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- Information Security Classification: ☐ Open ☑ Shared -Confidential ☐ Shared-Sensitive ☐ Shared-Secret

Public Health Protection Department- School Health Section

Student Medical Form & General Consent

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 Academic 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	☐ Yes	☐ No	ID Number: ....
Student's Passport Copy	☐ Yes	☐ No	
Original Vaccination Card or Updated Copy	☐ Yes	☐ No	
Health Card Copy (if any)	☐ Yes	☐ No	Health Card Number: ....
Health Insurance Card Copy (if any)	☐ Yes	☐ 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			
2	Does the student suffer from any Cardiovascular problem?			
3	Does the student suffer from Diabetes?			
4	Does the student suffer from Hypertension?			
5	Does the student suffer from Bronchial Asthma?			
6	Does the student suffer from any Renal Problem?			
7	Does the student suffer from Epilepsy or Convulsion /seizures?			

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Public Health Protection Department- School Health Section

Student Medical Form & General Consent

8	Does the student suffer from Epistaxis?			
9	Does the student suffer from Hemolytic Anemia, type G6PD?			
10	Does the student suffer from any Hereditary Blood Disease (e.g. Thalassemia, sickle cell anemia, Hemophilia)? If yes, please specify in comments			
11	Does the student suffer from any Skin Problem?			
12	Does the student suffer from any Eye problem (Myopia, Hyperopia…)? If yes, please specify in comments			
13	Does the student suffer from any Hearing problem?			
14	Dose the student use any medical aid device? If yes, please specify the device details in comments			
15	Did the student undergo any surgery in the past? If yes, please specify the details in comments			
16	Was the student ever hospitalized? If yes, please specify the reasons in comments			
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			
18	Did the student get any blood, antibodies or plasma transfusion in the past?			
19	Did the student suffer from any of the following diseases: (Mumps, Measles, Diphtheria, Pertussis, Chickenpox, Tuberculosis), If yes, please specify details in comments			
20	Did the student suffer from Viral Hepatitis?			
21	Did the student suffer from Poliomyelitis (Infantile paralysis infection)?			
22	Does the student suffer from any Mental or Behavioral Problem? If yes, please specify in comments			
23	Does the student suffer from any other Problem or disease not mentioned here? If yes, please specify in comments			

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

……

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Public Health Protection Department- School Health Section

Student Medical Form & General Consent

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			
2	Diabetes			
3	Any Hereditary Blood Disease (e. g. Thalassemia, sickle cell anemia, Hemophilia)			
4	Any type of Cancer			
5	Any Immune System problem			
6	Any Mental Health problem			
7	Others, please specify in comments			

I agree for my child to have curative and/or preventive services that may include first aid, screening for height, weight, vision acuity, hearing test, dental checkup, Back examination scoliosis screening, Comprehensive Medical Examination, referral to emergency room when necessary, administer emergency medications when needed, and applying the Healthcare Management plan which is planned for based on the instructions of the

Parent/ Guardian approval and verification for the above mentioned information

☐ **I certify that the above provided information are valid**

☐ **I agree for my child to be provided with the above mentioned health services according to the need**

☐ **I disagree for my child to be provided with the above mentioned health services (**In case of refusal, the above services will not to be offered except in emergency situations which require immediate intervention)

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**

Public Health Protection Department- School Health Section

Student Medical Form & General Consent

School.

- **This consent has to be filled each academic year and updated whenever required**

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