Does your child have any special dietary requirements, if so please give details

EMERGENCY CONTACTS

Mother Telephone Number

Father Telephone Number

Home Telephone

Alternative Contacts

Name Telephone Number

Name Telephone Number

If the above contact numbers cannot be reached, I give Awsaj Academy Administration / Medical staff permission to seek appropriate emergency treatment for my child.

☐ Yes ☐ No

Doctor's contact details (if you cannot be reached)

Doctor's Name Mobile Telephone

Work Telephone Fax

I hereby give Awsaj Academy permission to:	Yes	No
Administer non-prescriptive medications to my son/daughter	☐	☐
Administer first aid to my son/daughter	☐	☐
Send my son/daughter to a hospital in times of extreme emergencies	☐	☐

Parent's Signature Date

MEDICAL FORM

Dear Parent,

Please complete the attached form. It is important for us to be aware of any medical history/ conditions your child may have so that we can provide appropriate care while he or she is at school.

Awsaj Academy has a strict medicine policy that requires all medicines sent to school to have a medication request form filled in and signed by the parents. This form is available from the School Nurses' office. No medication from home will be given without written instructions.

Prescription medication is to be brought to school in the original container appropriately labeled by the pharmacy or doctor stating the child's name, name of the prescribing doctor, name of the medication, dosage, and time to be given. Non-prescription medication is to be brought to school in the original container with all labels intact. All medications must be dropped at the School Nurses' office by a parent or guardian. Students should not be in possession of or self administer any medication unless given permission by the School Nurse.

The information contained in this form will also be released to other school staff who have custodial care of your child and who may need to know this information to maintain your child's health and safety.

It is essential that you provide this information since we will use these details before any medicine or treatment can be given.

If you have any questions regarding this form, please do not hesitate to contact us.

Yours sincerely,

School Nurses
Tel # 44542099, 44542836

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MEDICAL FORM

For Office Use Only

Grade

Full name of student

First name

Middle name

Family name

Nationality

Date of birth Month Day Year Age

To be completed by physician

Height Weight Blood Group

Vital signs BP Pulse rate Respiratory rate

Visual acuity Right eye Left eye

Remarks

Auditory acuity Right ear Left ear

Remarks

Does she/he wear a hearing aid? ☐ Yes ☐ No

Physical assessments

ENT

Cardiovascular

Skeletal/Muscular

Scoliosis check (for nine-year-olds and above)

Immunization status Updated to what age?

Action plan for any medical problem(s)

General comments

Clinic name/Details

Date

Physician's name Physician's Signature

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MEDICAL FORM

Please complete all the sections of this form.

To be completed by parent/guardian

Medical history	Yes	No
Asthma	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Urinary disorder	☐	☐
Scoliosis	☐	☐
Tuberculosis	☐	☐
Heart disorder	☐	☐
Vision problem	☐	☐
Hearing problem	☐	☐
G6PD	☐	☐
Headaches	☐	☐

1 - Phobias

Please specify

2 - Other illness

Please specify

If you answered yes to any of the above, please give details

What medicines or other supplies should be kept at school for your child's condition?

Does your son/daughter have a physical disability that would require adaptations for him/her to participate in Physical Education safely?

☐ Yes ☐ No

Allergies

Food

Medicine

Other

Skin problem

Eczema

Psoriasis

Other

Does your son/daughter wear glasses?

☐ Yes ☐ No

Does your son/daughter wear contact lenses?

☐ Yes ☐ No

Has your child had surgery/hospitalization in the past?

☐ Yes ☐ No

If yes, please provide details, including date/year and medical reason

Date of last tetanus injection or booster

Is there any other special health information (past or present) that we should know about? Please provide details

Date

Name

*Please enclose a copy of your child's current immunization records.