



HEALTH INFORMATION 2024-2025

Part 1

Please complete this health information form. The information provided will remain confidential by all staff. Please help us to keep your child safe by providing any details that we need to be aware of failure to do so may jeopardize the safety of your child.

Student's Name: Last:	First:	Middle:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
			Nationality:	
Home telephone	Father's Mobile:	Mother's Mobile:		
My child has a medical condition that may affect his or her school day:			<input type="checkbox"/> No	Yes <input type="checkbox"/>
Parent's or Guardian's Name:				
Parent's Or Guardian's Signature:			Date:	

Part 2

Tick all boxes that apply to your child. Parent or guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. If your child has an individual Health Care Plan, the parent or guardian is responsible for providing the school nurse and registrations department with the necessary medical information and authorization forms.

1. ALLERGIES Please complete EpiPen Authorization form if applicable

Allergy type:

<input type="checkbox"/> Food Please specify	<input type="checkbox"/> Medication Please Specify	<input type="checkbox"/> Bee Sting
<input type="checkbox"/> Other		

Reactions:

<input type="checkbox"/> Coughing	<input type="checkbox"/> Hives	<input type="checkbox"/> Rash
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Local Swelling	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Generalized Swelling	<input type="checkbox"/> Nausea	<input type="checkbox"/> other

Currently prescribed medicines to be used in School

<input type="checkbox"/> Oral Antihistamine	<input type="checkbox"/> EpiPen
<input type="checkbox"/> Other:	

2. ASTHMA OR REACTIVE AIRWAY DISEASE (Please complete inhaler authorization form if applicable)

Triggers:

<input type="checkbox"/> Exercise Please specify	<input type="checkbox"/> Environmental Please Specify
<input type="checkbox"/> Other:	



Symptoms or Reactions:

<input type="checkbox"/> Chest tightness, discomfort or pain	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Itchy throat, tightness or soreness
<input type="checkbox"/> Coughing	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Other:		

Currently Prescribed treatments to be used in school

<input type="checkbox"/> Inhalers	<input type="checkbox"/> Oral Antihistamines	<input type="checkbox"/> Oral steroids
<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Oral Bronchodilators	<input type="checkbox"/> Peak Flow Monitoring
<input type="checkbox"/> other		
<input type="checkbox"/> Date of last hospitalization related to asthma		

3. DIABETES (Please complete procedure authorization form if applicable)

Currently prescribed treatments to be used in school

<input type="checkbox"/> Insulin	<input type="checkbox"/> Syringe	<input type="checkbox"/> Pen
<input type="checkbox"/> Pump	<input type="checkbox"/> Blood Sugar Testing	<input type="checkbox"/> Glucagon
<input type="checkbox"/> oral medications Please list oral medications		
<input type="checkbox"/> Is special scheduling of lunch or physical education required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

4 SEIZURE DISORDER

Type of seizure:

<input type="checkbox"/> Absence (staring, unresponsive)	<input type="checkbox"/> Complex Partial	<input type="checkbox"/> Generalized tonic-clonic grand mal, convulsive
<input type="checkbox"/> Other Please explain:		
<input type="checkbox"/> Is special scheduling of lunch or physical education required	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
<input type="checkbox"/> Medications needed IN School?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Please List Medications		
<input type="checkbox"/> Date of last seizure:	<input type="checkbox"/> Length of seizure:	

Other Health Conditions: (Please see PART 3)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Condition Please Specify:	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Physical Disability Please specify	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Other Please provide details:
<input type="checkbox"/> Is special Scheduling of lunch or Physical Education required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medications needed IN SCHOOL?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Please List Medications		
<input type="checkbox"/> Special procedure required in school? (continuous or temporary as per physician)	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Please provide details:		
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Vision Conditions

<input type="checkbox"/> Contacts	<input type="checkbox"/> Glasses	<input type="checkbox"/> Other:
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Hearing Conditions:

<input type="checkbox"/> Hearing Aid(s)	<input type="checkbox"/> Other:
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Part 3

Additional Information: Please complete below table.

Illnesses	No	Yes/ Date	Conditions	No	Yes/Date/Details
Chicken Pox			Major Illness/ Hospitalization (Including surgery)		
Diphtheria					
Dysentery			Significant Injury/Accident		
Infective Hepatitis					
Measles			Recurrent Tonsillitis, Sore Throat, Ear Infections		
Meningitis					
Mumps			Frequent Gastric Problems, Stomach Aches		
Poliomyelitis					
Rhematic Fever			Blood Disorders, G6PD Deficient		
Rubella(German Measles)					
			Frequent Headaches, Concentration Difficulties		
Scarlet Fever			Emotional/Behavioral issues, Weight/Eating Concerns		
Tuberculosis					
Whooping Cough			ADD, ADHD		
Other:			Nocturnal Enuresis (bed wetting)		
			Other:		

Part 4

Parent or Guardian consent for School Nurse to give First Aid Assessment and Treatment in school.

Parent or Guardian Name:

Parent or Guardian Signature:

Date:

Student Health Information is strictly confidential and will not be shared unless an illness or medical condition requires attention when the student is at school. Please return completed to the school Clinic as soon as possible.

Clinic email Id: Clinic_cia@gemsedu.com



MEDICAL CONSENT FORM

Name of student:

Year & Section:

Consent for Medication

If your child is unable to take certain medications, please contact the school Nurse to discuss the use of an alternative medication

Yes No

The school has permission to give my child nonprescription medicines should it be considered necessary by the school nurse. The nurse will always try to call you first to discuss her decision to give medication.

Emergency Treatment

The school nurse will attempt to contact you should an emergency arise

Yes No

In the event parents cannot be contacted, I authorize and empower GEMS Cambridge International School – Abu Dhabi Nurse or a School Administrator to make any and all decisions concerning the medical and/or surgical care of the child, which may include administration of EPIPEN and taking the child to a doctor or hospital for emergency treatment.

School Screening

As per the Department of Health Abu Dhabi (DOH), your child receive annual screening tests which consist of:

- Medical History
- Body Mass Index (BML percentile)
- Vision Screening (Eye test)
 - Blood Pressure Checking for Year 2, 6 & 10

YES No I consent for the school Nurse to screen my child as per the DOH recommendations

Parent/Guardian Name:

Signature:

Date: