BRITISH INTERNATIONAL SCHOOL RIYADH

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MEDICAL REPORT

Mandatory requirement prior to admission

Child's Family Name:		Child's First Name:	
Girl / Boy	Date of Birth (day/month/year):		
Home Address:			Home Phone:
Father's Name:	Occupation:		Work Phone:
Mother's Name:	Occupation:		Work Phone:
Emergency Contact Name:		Contact Numbers: /	
Mobile Numbers: Father:	Mother:		Emergency:

CONSENT TO INITIAL CARE BY AL MOUWASAT HOSPITAL I consent to arrangements being made, in an emergency, for my child to receive initial treatment from the Al Mouwasat Hospital and the 24 hour policy following assessment by Clinic Staff.		
Print Name:	Signature:	Date:

CONSENT TO TREATMENT BY SCHOOL NURSES I consent to my child receiving the necessary treatment and/or medication from a qualified school nurse.		
Print Name:	Signature:	Date:

Does your child have any special medical problems?
Does your child take medication regularly? Yes / No If yes, please give details:
Is your child allergic to anything, including medication? Please give details:

Please update the clinic regarding new or changes to any health issues

Please complete the 'HEALTH HISTORY' below and ask your doctor to complete the "MEDICAL REPORT' when he examines your child.

HEALTH HISTORY

To be completed by <u>parent</u> and reviewed by <u>family physician</u>

Mandatory	**Immunization Dates**			**Pre-School Booster**	**10 – 14 years**
	1st	**2nd**	**3rd**	**4-5 years**	
Diptheria, Pertussis & Tetanus (DPT)					
Polio (Drops)					
Mumps, Measles & Rubella (MMR)					
Rubella (German Measles) *Girls only*					
Tuberculin Skin Test (M)	Date:		Pos:	Neg:	
BCG Vaccination	Date:				

Recommended Immunization

Hepatitis	Date:
Meningitis	Date:

Has your child had any of the following (tick applicable box) and write any further comments below or attach a letter giving full details.

☐ Chicken Pox	☐ Measles	☐ Athletes Foot
☐ Hepatitis	☐ Meningitis	☐ Verruca
☐ Heart Condition	☐ Migraine	☐ Diabetes
☐ Eczema	☐ Coordination Problems	☐ Orthopedic Problems
☐ Vision / Eye Problems	☐ Hearing / Ear Problems	☐ Epilepsy / Convulsions /Seizures
☐ Speech Difficulties	☐ Concentration Problems	☐ Behavioral Problems
☐ Hospitalisation and/or operations:		
☐ Asthma: takes medication? Yes/No. If yes, please supply an inhaler/medication to be kept in the school clinic for routine/emergency use.		
Any other relevant medical information:		

Is there anything the school should know regarding your child's health that is not mentioned on this form. If so, please state: _____

If your child is to be administered medication form your doctor during school hours, it will only be given with an accompanying letter from the parents or doctors. If you give your child medicine before he/she comes to school **please** inform the nurse.

MEDICAL REPORT

To be completed by family physician

History (Please review parent's history and make any pertinent additions). Current immunization for diphtheria, tetanus, poliomyelitis, tuberculosis skin test and BCG (if indicated – TB is prevalent here), hearing (audiometry), vision tests.

Child's Family Name:	Child's First Name	Age:
Date of examination (day/month/year):		

Physical Examination

Height:	Weight:	Development:
Eyes: Vision (with/without) spectacles	Right:	Left:
Ears: Hearing (Audiometry)	Right:	Left:
Please attach copies of investigation reports where possible		

Based on current history and physical examination, I find the above named student free of contagious disease, vaccinated in accordance with the above mandatory school requirements and fit for all usual school activities.

_____ _____

Doctor's Signature (include physician / clinic stamp) **Date**

_____

Parent's Signature