



GEMS WELLINGTON مدرسة جيمس ولينجتون
INTERNATIONAL SCHOOL انـــــــترنـــــــادونال

Medical & Immunisation Record & Consent Declaration

Confidential

Child's Name _____ Class _____

Date of Joining GEMS Wellington International School _____

Name of previous School _____

Town / City _____ Country _____

Please submit prior to your child starting at GEMS Wellington International School

PO Box 37486, Dubai, United Arab Emirates

Tel: +971 4 348 4999, Fax: +971 4 348 6595

Web: www.wellingtoninternationalschool.com

www.gemseducation.com

Please complete **all** sections of this Medical & Immunisation Record & Consent declaration and return it to the school. **It is compulsory that this form is received prior to your child commencing at GEMS WELLINGTON INTERNATIONAL SCHOOL.**



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[Linkedin.com/company/gems-education](https://www.linkedin.com/company/gems-education)
[@gemseducation](https://twitter.com/gemseducation)
gemseducation.com



GEMS WELLINGTON مدرسة جيمس ولينجتون
INTERNATIONAL SCHOOL انجمن رناد ورنال

The information provided will be treated as confidential by all staff. If you have any queries, please feel free to contact a school nurse, who will be happy to answer any questions.

Name of child		Class	
Nationality		Date of Birth	
Gender (please circle)	Male / Female	Home Telephon	
Fathers Name		Mothers Name	
Fathers Mobile #		Mothers Mobile #	
Alternative Emergency Number		Contact Name	
Family Doctor / Clinic Name		Telephone No	

Does your child have siblings at GEMS Wellington International School?

No / Yes – name & class



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Has your child suffered from any of the following? If yes, please indicate dates in the Yes box.

Illnesses/conditions	YES Dates	NO	Illnesses/conditions	YES Dates	NO
Diphtheria			Serious Accidents		
Dysentery			Allergies / Eczema		
Infective Hepatitis			Bronchial Asthma		
Measles			Congenital Heart Disease		
Mumps			Diabetes Mellitus		
Poliomyelitis			Epilepsy / Seizures		
Rubella			G6PD (Glucose 6-Phosphate dehydrogenase deficiency)		
Scarlet Fever			Rheumatic Fever		
Tuberculosis			Thalassaemia		
Whooping Cough			Surgical Operations		
Chicken Pox			Frequent Gastric Problems		
ADHD			Frequent Headaches		
Nocturnal Enuresis			Vision Problems / Glasses		
Other			Hearing Problems		

History of: Blood Transfusion Yes / No Hospitalisation Yes / No

Is your child taking medication at present? Yes / No



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 INTERNATIONAL SCHOOL المدرسة الدولية

Please explain any **Yes** responses to the above in more detail, including treatment, dates and any medications taken on a regular basis, as a result. If you have any other concerns about your child, please mention them here.

Please continue on a separate sheet if necessary.



Family History: (Please specify relationship to student)

- Diabetes Hypertension Stroke
- Tuberculosis
- Other

Please note that if your child commences any new medication, treatment or changes their existing medication, the School Nurse must be informed.



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INTERNATIONAL SCHOOL الامارات

CERTIFICATE OF IMMUNISATION

Please attach a photocopy of your child's immunisation record.

The Department of School Health requires that the school maintains current information of each child's immunisation history.

I confirm that attached is a true copy of my child's immunisation record.

Name of student _____

Name of parent _____ (Please Print in Capital Letters)

Signature _____ Date _____

PARENTAL CONSENT

As the parent / guardian of _____ (print child's name), I give my consent to the following.

1) CONSENT FOR THE ADMINISTRATION OF PARACETAMOL

In the event that your child develops a fever or has pain it may be necessary to administer Paracetamol. If your child is unable to take this medication, please contact the School Nurse to discuss the use of an alternative.

I consent to my child being given Paracetamol, should it be considered necessary, by the School Nurse.

Name of Parent _____ (please print)

Signature _____ Date _____





2) CONSENT FOR MEDICAL EXAMINATION

According to the Department of School Health guidelines, children require a medical examination at various key stages in their lives.

This service is currently offered to you by Wellington, however, if you prefer to have your child examined by your own family GP you may do so at your convenience. The school will require a copy of the doctor's report to keep on file in your child's school health record.

We would also like to reassure parents that the safety and wellbeing of the children are of prime importance to us and they are supervised at all times during the examination by the School Nurse.

As parents, you will be notified prior to the examination.

I consent to my child having a medical examination at school

Name of Parent _____ (please print)

Signature _____ Date _____

Please note that all consents are valid for the duration of time that your child attends GEMS Wellington International School.

EMERGENCY TREATMENT

In the event that your child requires emergency treatment you will be contacted and asked to collect your child from 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 understand that my child will be taken to a doctor / hospital in the event of a medical emergency.

Name of Parent _____ (please print)

Signature _____ Date _____



GEMS Wellington International School Infection Control Policy:

In order to reduce the spread of illnesses in school, the following regulations apply.

1) Please DO NOT send your child to school if they have:

- a fever.
- a skin rash
- vomiting (*not to return to school for 24 hours after the last vomiting episode*)
- diarrhoea (*not to return to school for 24 hours after the last episode of diarrhoea*)
- a heavy nasal discharge
- a sore throat
- a persistent cough
- red, watery and painful eyes, especially if there is a yellow discharge.

2) If they have an infected sore or wound it must be covered by a well sealed dressing or plaster.

3) If your child is assessed by the school medical team and thought to be a possible source of infection to other students and staff, you will be contacted to take them out of school immediately.

Please inform the school if your child has been or is being treated for a medical condition.

I have read and understand the above infection control policy.

Signed _____ Date: _____