

Jumeirah English Speaking School



# Medical Record & Consent Declaration

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Student's Name

**Confidential**

Arabian Ranches  
P O Box 24942  
Dubai  
Direct Line+971 4 4224618  
Tel +971 4 3619019 Ext 214  
Fax +971 4 3615339

[healthoffice@jess.sch.ae](mailto:healthoffice@jess.sch.ae)

**Please complete and return to JESS prior to your son/daughter  
joining Sixth Form**

**It is compulsory that this form is received prior to your son/daughter commencing at JESS**

The information provided will be treated as confidential by **all** staff. If you have any queries please feel free to contact the Health Office, where the staff will be happy to answer any questions.

<b>Name</b>		<b>Date of Joining</b>	
<b>Nationality</b>		<b>Date of Birth</b>	
<b>Gender</b> <i>please circle</i>	<b>Male / Female</b>	<b>Home Telephone</b>	
<b>Father's Mobile</b>		<b>Mother's Mobile</b>	

**In case we need to contact you urgently and we are unable to reach you, please give an alternative emergency contact**

<b>Contact Persons Name</b>	
<b>Contact Persons Number(s)</b>	

**Please provide details of your family doctor and clinic**

<b>Clinic Name</b>	
<b>Doctors Name</b>	
<b>Telephone:</b>	

**Family History:**

<input type="checkbox"/>	<b>Diabetes</b>	<input type="checkbox"/>	<b>Hypertension</b>	<input type="checkbox"/>	<b>Stroke</b>	<input type="checkbox"/>	<b>Tuberculosis</b>
<input type="checkbox"/>	<b>Other, Specify</b>						

**Past Medical History:**

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**Chronic Medical Conditions:**

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**Current Medications: (if any)**

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**PARENTAL CONSENT**

As the parent / guardian of \_\_\_\_\_ (student's name)

I hereby consent to the following and understand that **all** consents are valid for the duration of time that my son/daughter, named above, attends Jumeirah English Speaking School.

Name of parent / guardian \_\_\_\_\_ ( Please print )

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR THE ADMINISTRATION OF SIMPLE, OVER THE COUNTER MEDICINES**

E.g. Panadol tablets/syrup; Ibuprofen tablets/syrup; Antihistamines tablets/syrups and other such non prescription medicines.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR EMERGENCY TREATMENT**

**In the event that your son/daughter requires emergency treatment you will be contacted and asked to collect your them from school. If the school is unable to contact you, your son/daughter will be taken to a doctor/hospital for diagnosis and treatment. Efforts to contact you will continue.**

I consent to my son/daughter being taken to a doctor / hospital in the event of a medical emergency.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**VACCINATIONS**

The Department of School Health requires that the school maintains current information of each child's immunisation history. A vaccination schedule is normally completed by the age of 15years.

I confirm that my son/daughter this has completed a full childhood vaccination schedule.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL EXAMINATION**

School Health guidelines recommend that young persons should undergo a physical examination at certain key stages in their lives, this should be done prior to leaving Sixth Form.

Please have this done by a GP of your choice and a copy of the report must be submitted to the JESS Health Office for inclusion in the school health record maintained by the school.

I confirm that I will submit the GP report of the physical examination on my son/daughter for inclusion in their school health records

Signature \_\_\_\_\_ Date \_\_\_\_\_