MEDICAL DECLARATION AND MEDICAL TREATMENT CONSENT FORM

Student's Name________________________________ Male/Female Nationality_________________

Date of Birth (Day/Month/Year)_______________ Religion_________________ Year Group_______

In consideration for accepting my child as a student in Star International School, Al Twar, I hereby give consent for my child to receive first aid treatment as necessary according to the school doctor/nurse or concerned school authority's discretion. I also authorize the school to transport my child to the nearest clinic/hospital for medical treatment in cases of emergencies as deemed necessary. I further agree that I will disclose all significant information(s) concerning my child's medical/behavioural condition, if any. I also agree that the school will not be held liable for any eventualities that may arise by non-disclosure of such significant medical information.

I give consent for my child to have a medical examination when necessary by the doctor Yes ☐ No ☐

This waiver/consent is valid on the date of signing and for the whole duration of my child's stay in Star International School, Al Twar and will inform the school for any change(s) of information(s) stated on this form.

Father/Mother's Name: ____

Full Address: ____

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Contact Details:
Father (Mobile): ______________________________ Work: ______________________

Mother (Mobile):______________________________ Work: ______________________

Father's Email Address:____

Mother's Email Address: ____

Residence Phone Number: ____

Other Person to notify if unable to contact parents – Name: ______________________________

Relation to Child: ________________________ Contact Number: ______________________

Insurance Information (if applicable)**:**
Name of Insurance Company: ____

Policy Holder's Name: ________________________ Relationship to Child: ________________

Policy Number:_________________________________ Expiry Date: ______________________

Parent/Guardian's Signature:______________________________ Date:____________________

CONSENT FOR IMMUNISATION

Name of the Child: ____

Date of Birth: ____

Class/Grade: ____

Please tick YES or NO

I give consent for the Immunisation of my child ☐ Yes ☐ No

Name and Signature: ____

Please provide the following information to update your child's school health record and give a copy of his/her Immuisation Card.

Child's History of Illness:

Please tick appropriately. If yes, please specify the Month and Year of illness.

INFECTIOUS DISEASES	YES	NO
Diptheria		
Dysentery		
Infective Hepatitis		
Measles		
Mumps		
Poliomyelitis		
Rubella		
Scarlet Fever		
Tuberculosis		
Whooping Cough		
Chicken Pox		

NON-INFECTIOUS DISEASES	YES	NO
Accidents		
Allergies		
Bronchial Asthma		
Congenital Heart Disease		
Diabetes Mellitus		
Epilepsy		
G6PD (Glucose6-phospate dehydrogenase deficiency)		
Rheumatic Fever		
Surgical Operation		
Thalasaemia		

History of: Blood Transfusion ☐ No ☐ Yes Frequency ______________________

Date ______________________

Hospitalisation ☐ No ☐ Yes Reason ______________________

Date ______________________

Family History:
☐ Diabetes ☐ Hypertension ☐ Mental Disorders ☐ Stroke ☐ Tuberculosis ☐ Other,Specify

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Licensed School Nurse