



المدرسة الإنجليزية الحديثة  
THE ENGLISH MODERN SCHOOL  
CAMBRIDGE CURRICULUM

STUDENT NAME: \_\_\_\_\_ YEAR LEVEL: \_\_\_\_\_

**MEDICAL DECLARATION FOR THE ACADEMIC YEAR 2017 - 2018**

In order to ensure a healthy and safe environment, it is important that the school be made aware of any medical conditions of your child. Please complete the following by marking (✓) for yes and (X) for no.

**A. SPECIAL CONDITIONS:**

- DIABETES
- HEART DISEASE      DETAILS: \_\_\_\_\_
- HIGH BLOOD PRESSURE (HYPERTENSION)
- CNS CONDITION:       EPILEPSY       OTHER: \_\_\_\_\_
- BLOOD DISORDER:       ANAEMIA       HAEMOPHILIA       OTHER: \_\_\_\_\_
- ALLERGIES:       FOOD: \_\_\_\_\_       MEDICINE: \_\_\_\_\_       OTHER: \_\_\_\_\_
- Provide Epinephrine pen if your child had severe allergic reaction / required hospitalization before.*
- MEDICAL REASON FOR NOT TAKING PART IN PE: \_\_\_\_\_

If you marked (✓) yes for any of the above medical conditions and prior to final acceptance at EMS, the school will provide additional medical forms to be completed.

Student will be officially enrolled only after the appropriate forms have been submitted and reviewed by the school's medical staff.

**B. OTHER CONDITIONS:**

- ASTHMA:       INHALER USED: NAME: \_\_\_\_\_       OTHER MEDICATION: \_\_\_\_\_
- G6PD: Did this condition require hospitalization?       YES       NO      Notes: \_\_\_\_\_
- MAJOR SURGERY DETAILS: \_\_\_\_\_      DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_
- HEARING DIFFICULTY       HEARING AID
- EYESIGHT DIFFICULTY:       WEARS GLASSES       USES CONTACT LENSES       OTHER EYE PROBLEMS: \_\_\_\_\_
- BONE DISORDER      NAME: \_\_\_\_\_      MEDICATIONS: \_\_\_\_\_
- OTHER CHRONIC DISEASE: \_\_\_\_\_
- OTHER REGULAR MEDICATIONS: \_\_\_\_\_
- DIAGNOSED LEARNING DISABILITY: \_\_\_\_\_

- I give permission to the school clinic staff (nurse or doctor) to give "Adol" or "Panadol" to my child if the need arises.
- I give permission to the school medical staff to share medical information about my child with other staff members when that information is necessary for the medical well-being of my child.

**I HEREBY CERTIFY THAT THE INFORMATION I PROVIDED IS COMPLETE AND ACCURATE.**

FULL NAME: \_\_\_\_\_ RELATIONSHIP TO CHILD: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_