Al Dhafra Private Schools
Abu Dhabi Educational Council

مـــدارس الظـفـرة الخـاصـــة
منطقة أبوظبي التعليمية

STUDENT'S HEALTH RECORD

FULL NAME:				NATIONALITY:	
DATE OF BIRTH:		GENDER:		GRADE:	
PARENTS' INFORMATION:					
NAME:		MOBILE NO:		EMAIL ADDRESS:	
IN CASE OF EMERGENCY CONTACT:					
NAME:		MOBILE NO:		RELATIONSHIP:	

1. Does your child have any serious medical conditions such as diabetes, asthma, epilepsy, etc.? · No · Yes If yes, please specify and attach a copy of Medical Report.
2. Does your child have any hearing, sight or speech problems? · No · Yes
3. Has your child ever undergone a surgery? · No · Yes If yes, please specify.
4. Does your child have any allergies to medications? · No · Yes If yes, please specify.
5. Does your child have any food allergies? · No · Yes If yes, please specify.
6. Does your child take regular medication? · No · Yes If yes, please specify.
7. Do you give the school permission to give your child medicine (Adol or Panadol) in case of fever, headache or pain? · No · Yes
8. Does your child have any special needs or care? · No · Yes If yes, please specify.

NB: Any change in your child's health that is not reported to the school may delay administrative procedures. Therefore, report any changes at the earliest possible time.

I Mr. / Mrs.________________________ Parent of ______________________________ Grade____________ declare that all the information given above is true. And I give my consent to allow the school doctor or the school nurse to take all necessary measures in case of injuries or sickness (first aid care and available medicine).

Parent's signature: ____________________
Date: _________________________