BISAK

PUPIL MEDICAL FORM

By signing each page of the document in the School's Pupil Medical Form you agree you have read, understood and accept the School's Medical Policies and Requirements and have supplied the school with all the information requested.

Failure to declare any information regarding your child's health may result in the loss of your child's place at the School.

Pupil Information		
First Name	Middle Name	Last Name
Name to be used in school if different to above:	Date of Birth (DD/MM/YYYY)	Gender ☐ F ☐ M
Iqama (ifavailable)	Iqama No.	Iqama Expiry Date

Emergency Contact Information		
Father/Guardian Name	Father mobile	Father Office/Daytime landline
Father Email	Home Phone	
Mother/Guardian Name	Mother mobile	Mother Office/Daytime landline
Mother Email	Home Phone:	
Emergency Contact Other than Parents - please inform the person listed that you have given their name to BISAK. They will only be contacted if parents cannot be reached on the above details.	Alternative Contact Name	
Alternative Contact Mobile	Alternative Contact Landline/Daytime Number	
Alternative Contact Email	Relationship to Pupil	

Medical Emergency Policy

- In the event of a medical emergency, the School Nurse will attend to the patient. If necessary, the patient will be taken to the nearest medical centre or hospital. The School Nurse may not necessarily accompany the patient.
- If deemed necessary by the Nurse, an additional adult will accompany the patient.
- The child's parents will be contacted as soon as practical. If the parents are unavailable then the School will call the above nominated emergency contact.
- The School Nurse or trained First Aiders will act in *loco parentis* until such time as the child's parent/guardian or nominated emergency person is in direct contact with the appropriate medical staff.
- The Pupil Medical Form may be provided to the hospital.

Staff Signature:
Date:

Parent/Guardian Signature	
Print Name	Date

BISAK

Pupil		
First & Middle Name	Last Name	Date of Birth (DD/MM/YYYY)

Immunisation Requirements

Immunisation requirements for Pre-school (aged three, turning four)	Parent to complete		Office use only
BCG or Negative PPD test (to be repeated every 2 years)	☐ Yes	☐ No	☐
MMR (Measles, Mumps, Rubella) – 1st dose	☐ Yes	☐ No	☐
DTP/Hib (Diphtheria, Tetanus, Whooping Cough and Heamophilus Influenza B) – 3 doses at 2, 3 & 4 months.	☐ Yes	☐ No	☐
Oral Polio – 4 doses or 3 doses of IPV	☐ Yes	☐ No	☐
Immunisation requirements for all children aged three years and four months or soon after including all vaccinations listed above AND the following:			
DTP and Polio - Pre-School Boosters	☐ Yes	☐ No	
MMR 2nd dose of MMR if not already given	☐ Yes	☐ No	
Immunisations required for all children aged thirteen years and above (Year 9 entry and above) include all vaccinations listed above AND the following:			
DPT and Polio	☐ Yes	☐ No	
Meningococcal ACWY – 1 dose (recommended)	☐ Yes	☐ No	
Hepatitis A – 2 doses *(optional but recommended)*	☐ Yes	☐ No	
Hepatitis B – 3 doses *(optional but recommended)*	☐ Yes	☐ No	

Copy of Immunisation Documents

☐ I/We have attached a photocopy of the child's immunisation schedule, officially translated into English (if necessary). We confirm that we can provide the original copy of the child's current immunisation history if requested by the BISAK.

Your application cannot be processed, and your child will not be permitted to commence at

BISAK if you cannot produce a complete Immunisation Record.

You must have at least started any Hepatitis A/B courses

Any questions please contact the school nurse on +966 13 831 7300 Ext 112.

Parent/Guardian Signature	
Print Name	Date

Staff Signature:

Date:

BISAK

Pupil		
First & Middle Name	Last Name	Date of Birth (DD/MM/YYYY)

Medical History

Please complete the following, giving as much detail as possible; *include additional pages if necessary, sign and date all additional pages.*

If your child is taking *long term* medication or has a serious condition then a written Emergency Care Plan, provided by the nurse, must be completed, signed by the doctor and returned to the nurse before your child can commence school. The Emergency Care Plan and the medication supplied to the school must remain current and up-to-date for your child to remain in school.

Is your child allergic to any medicine, food or product? (eg penicillin, peanuts, etc)	☐ Yes	☐No
If you answered YES provide detailed information including: What was the reaction, when was the last incident and the medication used?		
Is your child taking any regular medication or under regular medical treatment? (eg. insulin, Ritalin, inhalers, anti-epileptic etc)	☐ Yes	☐No
If you answered YES provide detailed information:		
Does your child have any specific health, behavioural or emotional issues?	☐ Yes	☐No
If you answered YES provide detailed information:		
Does your child have any hearing/hearing related problems? (eg. grommets)	☐ Yes	☐No
If you answered YES provide detailed information:		
Does your child have any problems with eyesight or wear glasses?	☐ Yes	☐No
If you answered YES provide detailed information:		

Staff Signature:
Date:

Parent/Guardian Signature	
Print Name	Date

Pupil		
First & Middle Names	Last Name	Date of Birth (DD/MM/YYYY)

Illness History

Please complete the following, giving as much detail as possible; *include additional pages if necessary, sign and date all additional pages.*

Asthma	☐Yes ☐No	If YES provide as much detail as possible. When last attack, medication used, etc.
Allergies	☐Yes ☐No	If YES provide as much detail as possible. Reaction, Medication used etc
Diabetes	☐Yes ☐No	If YES provide as much detail as possible.
Eczema	☐Yes ☐No	If YES provide as much detail as possible.
Epilepsy	☐Yes ☐No	If YES provide as much detail as possible.
G6PD Glucose 6 Phosphate Dehydrogenase Enzyme Deficiency	☐Yes ☐No	If YES provide as much detail as possible.
Hospitalisation – has your child ever spent time in hospital?	☐Yes ☐No	If YES provide as much detail as possible.
Any other serious illness or medical condition	☐Yes ☐No	If YES provide as much detail as possible.

Staff Signature:
Date:

Parent/Guardian Signature	
Print Name	Date

BISAK

Pupil		
First & Middle Name	Last Name	Date of Birth (DD/MM/YYYY)

Consent Form

I DO consent to my child being given the following medication in school if necessary:

☐ Yes	Paracetamol (dosage given according to age)
☐ Yes	Ibuprofen (Brufen) (dosage given according to age)

Further requirements:

1. BISAK is a NUT FREE School. All food sent with your child must be nut free. Even though the food is being consumed only by your child, any remnant on their hands can be dangerous to others with nut allergies.
2. Please inform the school if your child will be absent from school when they are unwell or have a routine doctor or dental appointment.
3. The School Policy for children who have been ill requires that the child needs to be 24 hours free of fever without medication before being permitted to return to school. No child is to attend school until 48 hours after diarrhoea and vomiting.
4. If your child is taking a *short term* prescribed course of medication and has to take it during school hours then written Parental Consent must be given to the Nurse along with the medication in a bag at the start of the school day. Please write clearly your child's name, form class, time required and dosage of medication. No medication is to be kept in school bags, nor self administered.
5. If your child is taking *long term* medication or has a serious condition (eg. epipen, ventolin, allergies, etc) then a written Emergency Care Plan must be completed before your child can commence school.
6. Please notify the school Nurse immediately should your child contract any communicable diseases (eg. chickenpox or head lice) or should there be any significant change in their overall health. This helps us to ensure that the health of your child and the school as a community is optimised.
7. It is extremely important to update the school if there is any change to your contact details. Also, please inform the Nurse if both parents are leaving the country whilst your children are still in school and ensure that the school has the current contact details of a nominated emergency contact.

Please provide details below of any other issues regarding medical treatment which the School should be made aware of for your child that has not been covered in this document.

Staff Signature:
Date:

Parent/Guardian Signature	
Print Name	Date

BISAK

To be completed by a General Practitioner

Statement for Pupil Health Record

Pupil		
First & Middle Name	Last Name	Date of Birth (DD/MM/YYYY)

Based on the current history provided in this document and physical examination, I find the above pupil Free of contagious disease, vaccinated in accordance with the above mandatory school requirements and fit for all usual school activities.

I am not related to the pupil.

I have stamped signed and dated a photocopy of the vaccination record to be provided to BISAK.

GP Signature:		Date:
Print GP Name:		

Physician or Clinic Stamp below:

Staff Signature:
Date:

Parent/Guardian Signature	
Print Name	Date