UNITED ARAB EMIRATES
MINISTRY OF HEALTH & PREVENTION

الإمارات العربية المتحدة
وزارة الصحة ووقاية المجتمع

Student Medical History Form

Student No.: ....

Dear parent/ Guardian:

Kindly fill this form about the medical History of your Son /daughter by answering **Yes** or **No** . If any answers is Yes , please provide us with dates & details , Answers should be as accurate as possible. The student's Health is our priority.

Students Data :

Student's Name : .... gender :.................. Nationality:..................
Date of Birth: .... School: .... Class : ....
Guardian's Name : .... Relation to Student: ....
Religion : .... 1 st Language : ....

Student's / guardian's Contact :

Emirate :................................ City : .... area : .... Street : ....
Home phone NO.: .... Mobile phone No.: .... 2nd mobile No.: ....

Required documents :	**attached**		
- Passport Copy :	Yes ☐	No ☐	
- ID Card copy :	Yes ☐	No ☐	ID.No.: ....
- Health card copy :	Yes ☐	No ☐	No : ....
- Insurance card copy :	Yes ☐	No ☐	No. :..............................

No.	Health Concerns	Yes	No	Comments
1.	Does the students have any allergy or sensitivity to medications/food/ ....etc. please mention it if any...			
2.	Does the students suffer from any cardiac problems?			
3.	Is the student Diabetic?			
4.	Does the student have hypertension ?			
5.	Is the student asthmatic ?			
6.	Does the student suffer from any renal problem?			
7.	Did the student suffer previously from urinary tract infections?			
8.	Does the student suffer from epilepsy/ seizures ?			
9.	Is the student suffering from G6PD deficiency?			
10.	Does the student have any chronic blood disease? (Thalasemia, Anemia, Hemophilia ....etc.)			
11.	Does the student suffer from Recurrent epistaxis (nasal bleeding) ?			
12.	Does the student have any skin problems.			
13.	Does the student have any eye (ophthalmology) problems (visual disturbances) ?			
14.	Any previous surgical procedures done ?			
15.	Any previous admissions to hospital ? please mention			

16.	Is the student using any hearing /visual/walking/aids? IF Yes , what is it?			
17.	Did the student ever get mumps, measles, chicken pox?			
18.	Does the student suffer from any psychiatric/ behavioural problems?			

If the student has any health problem ,kindly answer the following questions:-
Type of problem /disease & date of onset : .... when was the last attack .... Name of hospital or health center where the student is getting treatment / follow up : .... Name of treating physician: ....
Long term medication used by the student :- **Name of Medication:** .... **Dose & frequency :** .... **Medication recommended in case of emergency :** ....
Dietary Recommendations: ....
Physical activity Recommendations: ....
Recommendations for the school nurse during the school hours: ....

Parent's/Guardian's Name & Signatures.. Date : ....

Note: Kindly attach any medical report with this form & send it back to the school nurse with the student .

Thank you