



## DOHA ENGLISH SPEAKING SCHOOL

PO Box 7660 • Doha • Qatar ▪ Tel: (974) 4870170 • Fax (974) 4875921 ▪  
e-mail [registrar@dess.org.qa](mailto:registrar@dess.org.qa) ▪ www.dess.org

### STUDENT HEALTH RECORD

Family Name		First Name		Date of Birth	
Tel home		Dad's Mobile		Mother's mobile	
Emergency Tel:					

PLEASE COMPLETE THE FOLLOWING HISTORY:  
**(Please attach a copy of your child's immunisation record with this form)**

	Immunization Dates			Pre-school Booster
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 – 5 years
Diphtheria, Pertussis & Tetanus (DPT)				
Polio (drops)				
Mumps, Measles, & Rubella (MMR)				
Rubella (German measles) Girls only				
Tuberculin Skin Test (M)	Date:		Pos: <input type="checkbox"/>	Neg: <input type="checkbox"/>
BCG Vaccination	Date:			

Please indicate with a tick if your child suffers from, or has had, any of the following:

Asthma – Which medication (if any):				
Chicken Pox		Epilepsy		
Ear/Hearing Problems		Eye/sight problems	Glasses?	<input type="checkbox"/>
Eczema		Measles		
Heart disorders		Physical disability		
Diabetes				

Is your child allergic to any food, medicine etc. Please state:
Has your child ever had an infectious disease, e.g. hepatitis:
Has your child ever had an operation? If, so please state:
Is your child on any regular medication? If so, please state:
Is there anything the school should know regarding your child's health that is not mentioned on this form? If so, please state:

If your child is to be administered a medication from your doctor during school hours, it will only be given with an accompanying letter from the parents or doctor. If you give your child any medication before he/she comes to school please inform the nurse.

Medication including paracetamol/calpol etc. cannot be administered by the school nurse without prior permission from a parent/guardian. It is the parent's responsibility to ensure that any change of contact numbers are provided to the school office without delay.

#### **Parental Consent**

If headlice are found within my child's year group, I agree to authorise the school nurse to inspect my child's hair.

I agree to take my child to his/her doctor or health clinic for a medical examination/tests, whenever such an examination, in the opinion of the Headteacher/Board of Governors, is considered to be necessary in the general interests of health and hygiene in the School and following this provide a certificate signed by a qualified practitioner.

In case of an accident or other emergency illness where I cannot be contacted as set down in the school procedure, I agree to the school taking appropriate action by contacting the emergency services or escorting my child to hospital.

Parent/Guardian's name: .....Signature: .....

Date: .....