مدرسة الأطياف العالمية
SPECTRA
SPECTRA GLOBAL SCHOOL

Medical & Social Form

Child's Full Name	
Admission Number	
Academic Year	20 2..... / 20 2.....
Class / Year Group	YR..... Group …….
Term (Please select)	Term 1 / Term 2 / Term 3

Please attach a copy of the health card, complete all sections of this form and return to the school ASAP

A – INFECTIOUS DESEASES (please tick ✓ where appropriate)			
Has your child ever had:	YES	NO	If yes, please state the date of infection
Chickenpox			
Diphtheria			
German Measles			
Measles			
Mumps			
Polio			
Scarlet Fever			
Tuberculosis			
Whooping Cough			
Hand, foot, mouth disease			
COVID -19			
B – OTHER CONDITIONS			
Does your child suffer from:	YES	NO	If yes, please give relevant details.
Asthma			
Epilepsy			
Diabetes			
Anaphylaxis			
Skin diseases			
Other (please give details) e.g. Tooth decay, tonsillitis:			

C – SERIOUS ILLNESS/MAJOR SURGERY			
Please give details of any **Illnesses**/ **Severe Injuries** *(breaks, etc.)* or **Surgeries** that your child has undergone:			
Incident	Hospitalized	After Effects	Further Details
	Yes ☐ No ☐	Yes ☐ No ☐	
	Yes ☐ No ☐	Yes ☐ No ☐	

	Yes ☐ No ☐	Yes ☐ No ☐	
Other (please give details)			

D – SEN REQUIREMENTS			
Does your child have any diagnosed Learning Difficulties? Please disclose and provide All details in this regard.			
Impairment	Yes ☐	No ☐	If yes, please give details
Visual			
Hearing			
Attention Deficit ADHD			
Autism			
Asperger's Syndrome			
Other: *(Please Explain)*			

E – ALLERGIES			
Does your child suffer from any Allergies? E.g. Food, drug, environment, chemicals, sunlight, dander, insect- bites/stings/mites.	Yes ☐	No ☐	If Yes, PLEASE complete the following thoroughly

Ailment:	Trigger by:	Medication Taken [name, dose, frequency, route]
Other (please give details)		

F – MEDICATION			
Does your child need any regular medication?	Yes ☐	No ☐	If Yes, PLEASE provide all necessary details.
If So, please give details			
Does your child self-medicate?	Yes ☐	No ☐	If Yes, please provide the details:
Does your child need any medication for any emergency purpose?	Yes ☐	No ☐	If Yes, please mention the name of the medication, dose to administer, route and frequency
Contact Number of the Parent in case of an emergency			
Have you informed the school nurse and the class teacher and handed over the medication?	Yes ☐	No ☐	Name of Class Teacher: Name of School Nurse:

G – HEAD LICE			
Is your child free of head lice?	Yes ☐	No ☐	If Yes, has she/he undergone lice treatment, please mention the date:
Last date of the head lice check:			

H – EMERGENCY CONTACT DETAILS *(parents)*

In the case of an EMERGENCY, PLEASE make the necessary contact in the following Order ***(except parents)***				
Order	Name	Relationship to child	Contact Number/s	
1st				
2nd				
3rd				

I – MEDICAL INSURANCE DETAILS	**(Please attach a copy of the medical card)**		
Do you have Medical Insurance for your child		Yes ☐	No ☐
Medical Insurance Provider			
Medical Insurance Number			
Other: please provide any relevant details			

J – PERMISSION FORM		
Do we have permission to provide emergency care through a clinic, hospital, private doctor or school first aid person as necessary or call 999? (**NB – this MAY NOT be covered by your medical insurance company)	Yes ☐	No ☐
Do we have your permission to use BANDAID on your child in case of cuts/injuries?	Yes ☐	No ☐

WE WILL NOT BE ADMINISTERING ANY MEDICATION OTHER THAN THE EMERGENCY DRUGS THAT ARE HANDED OVER TO THE SCHOOL NURSE BY THE PARENTS [EPIPENS, INHALERS AND OINTMENTS FOR ALLERGIES AS PRESCRIBED BY THE PHYSICIAN].

KINDLY LABEL THE MEDICATIONS WITH THE DETAILS BEFORE HANDING THEM OVER TO THE SCHOOL NURSE.

K - SOCIAL INFORMATION		
Family Status	Answer	
	Yes	No
Living with parents		
Deceased Father		
Father remarried		
Deceased mother		
Mother remarried		
Divorced If divorced, please answer the questions bellow :		
With whom does your son/daughter live? ----------		
If your child has any social problem that is not mentioned above, write it below:---------- ----------		

L - DECLARATION:

- I hereby Confirm and Declare that ALL details provided by me on this form are Accurate and Up-to-Date.
- I will inform the SGS Administration of any changes to these medical details.
- I will abide by the guidelines that are approved by the Ministry of Public Health.
- I will not hold the School responsible for any reason, if it is found that the information provided on this form is incorrect or incomplete.

Parent's Name	Signature	Date (dd/mm/yyyy)