SHERBORNE QATAR

Date: Academic Year 2020/21

Dear Parents

During the school day, the medical team is visited by children who are unwell. Some of the children need minor treatment but some require medication to help them return to class and manage the day. To help provide the best care for your child, we ask you to give consent for us to administer medication and inhalers, if necessary. This is so children can be treated quickly and effectively. We will communicate this to you either as a note or a phone-call.

In addition, The Ministry of Education requires that we carry out an annual medical check on all school age children. This is to check height, weight, BMI, vision and teeth.

Please sign and return to your child's tutor as soon as possible the medical consent and medical history forms below. If you do not give permission you should still return the letter stating your decision. Please note the medical history form includes space for you to provide emergency contact information.

If you have any queries please do not hesitate to contact the school medical team on MS@sherborneqatar.org.

Thank you.

The School Medical Team

SHERBORNE QATAR

CONSENT FOR MEDICATION AND MEDICAL CHECKS

Child's Name: _____ School Year : **2020-2021**

Date of Birth: _____ Form:_____

1. Medication - I give permission for my child to receive the following:	✓
Paracetamol (for Fever, Headache, Pain reliever)	
Ibuprofen (Pain reliever, Anti-Inflammatory)	
Salbutamol Inhaler (Asthmatics/Dust Allergies only–Please provide the school with spare inhaler)	
Chlorpheniramine Maleate/Loratidine (Anti-allergy for insect bites, rhinitis, hay fever, common cold, runny/clogged nose)	
Rennie (Indigestion, Stomach upset, Heart burn, Hyperacidity)	
Strepsil/Zecuf (Sore throat/cough)	
Expectorant/Mucolytic (Cough relief)	
Motilium/Primperan (Nausea and Vomiting)	
Imodium/Biocarbon/Oresol (Diarrhoea)	
Dizzinil (Motion sickness)	

2. I give permission for my child to have a medical check as per Ministry of Public Health requirements (Height and Weight, Vision and Teeth)	

3. If required I give permission for my child to receive emergency care	

Parent / Guardian Name: _____

Signature: _____ Date:_____

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MEDICAL HISTORY

Please complete and return this form to your child's form tutor on the first day with details of any medical condition or regular medication that your child is taking.

Pupil Name:	D.O.B:	Form:
Allergies : (Food, drug, insect, other) **(Please collect care plan from medical room if child has allergies / chronic illness)**		
Skin Problem: (Eczema, Psoriasis, other)		

Asthma	Yes	No	Diabetes	Yes	No
Epilepsy	Yes	No	Headache	Yes	No
Nose bleed	Yes	No	Hearing problem	Yes	No
Motion sickness	Yes	No	Educational Psychology Report	Yes	No

Other illness: (please specify)	
Is your child currently taking any medication: (please list)	
Does your child wear glasses/contact lenses: Yes No	**Does your child have vision problem :** Yes No
Any other relevant health information:	
Please attach vaccination card copy for school record/reference.	

Has your child had: **Varicella (chickenpox)?** Yes No Vaccination	Has your child had: **German Measles (Rubella)?** Yes No Vaccination	Has your child had: **Measles?** Yes No Vaccination
Date of last Tetanus injection or booster:		

<u>Emergency contact details:</u>

Father's Name: **Mobile:**	**Mother's Name:** **Mobile:**	**Home Tel :**
Another adult who is able to collect your child: Name: Mobile: Home Tel:		

Updated May 2020