Qatar Foundation Schools Medical Form

Dear Parent,

Please complete the attached form. It is important for us to be aware of any medical history/conditions your child may have so that we can provide appropriate care while he or she is at school.

The school has a strict medicine policy that requires all medicines sent to school to have a medication request form filled in and signed by the parents. This form is available directly from the School Nurses' office. No medication from home will be given without this being completed.

Prescription medication is to be brought to school in the original container appropriately labeled by the pharmacy or doctor stating the child's name, name of the prescribing doctor, name of the medication, dosage, and time to be given. Non-prescription medication is to be brought to school in the original container with all labels intact. All medications must be dropped at the School Nurses' office by the parent or guardian. Students should not be in possession of or self-administer any medication unless given permission by the School Nurse.

The information contained in this form will also be released to other school staff who have custodial care of your child and who may need to know this information to maintain your child's health and safety.

It is essential that you provide this information since we will use these details before any medicine or treatment can be given.

If you have any questions regarding this form, please do not hesitate to contact us.

Yours sincerely,

School Nurse

Qatar Foundation Schools Medical Form

For office use only

Grade:

Student's information

First name: _____
Middle name: _____
Family name: _____
Nationality _____
Date of birth: Month: Day: Year: Age:

To be completed by physician

Height: Weight: Blood group:
Vital signs: BP: Pulse rate: Respiratory rate:
Visual acuity Right eye: Left eye:
Remarks:
Auditory acuity: Right ear: Left ear:
Remarks:
Does she/he wear a hearing aid? ☐ YES ☐ NO

Physical assessment

ENT
Cardiovascular
Skeletal/Muscular
Scoliosis check (from 9 years old)
Immunization status Updated to what age?
Action plan for any medical problem:

General comments:

Clinic name/details:
Date:

Physician's name: Physician's signature: