THE BRITISH INTERNATIONAL SCHOOL
ABU DHABI
A NORD ANGLIA EDUCATION SCHOOL

Annual Student Trip Medical Clearance Form

2018/19

VERY IMPORTANT: Please note that without completion of this form, your child will not be able to attend any school trips.

To ensure your child receives comprehensive health care in the event of an illness or injury whilst participating on a school trip, please answer every question fully. This information will be shared with the treating medical authorities present at the time.

Personal Information

Child's Name			
Date of birth		Nationality	
Gender		Class/Year	
Mother's name		Father's name	
Address			
Mother's mobile		Father's mobile	
Mother's email		Father's email	
Emergency no.			

Vaccination Details

		Year
Diphtheria ,tetanus, pertussis (DTP)	◯	
Measles ,mumps ,rubella (MMR)	◯	
Polio	◯	
Chicken pox (Varicella)	◯	

Child's Medical History

Please Note: if you answer yes to any of these questions, you must provide further details and indicate whether they require emergency medication.

Condition	Yes (Date)	No
ADHD	◯	◯
Allergies (please list reaction below)	◯	◯
Asthma (Please supply clinic with inhaler)	◯	◯
Congenital Heart Disease	◯	◯
Diabetes Mellitus	◯	◯
Epilepsy / Seizures	◯	◯
Frequent Gastric Problems	◯	◯
Frequent Headaches	◯	◯
Hearing Problems	◯	◯
Bed wetting / Day wetting	◯	◯
Serious Accidents/ Fractures	◯	◯
Thalassemia / G6PD	◯	◯
Vision Problems / Glasses	◯	◯
Other	◯	◯

Medication taken on a regular basis

For any 'Yes' responses in the child's medical history, please provide further details.

Note: If your child receives a new diagnosis or commences any new medication, treatment, or changes his/her existing medication, it is the parent's responsibility to contact the school nurse personally or via email on *school.nurse@bisad.ae*

Consent for the Administration of Medications and Emergency Treatment

In the event that your child becomes unwell, or he/she has injured him/herself, it may be necessary to administer specific medication or undertake treatment.

This is to authorize the School Nurse or trip leader to administer the appropriate treatment for the various situations that may arise.

Name of drug	Age	Dose	Indication	Remarks
Paracetamol Syrup 120mg/5mg	1 - 4 years	15mg/kg/ dose	Pain, Fever	Every 4 - 6 hours
Paracetamol Syrup 250mg/5mg	5-12 years; 5-10ml 12-18 years; 10ml	15mg/kg/ dose	Pain, Fever	Every 4 - 6 hours
Claritine 5mg/5ml	Under 30kg Over 30kg	5ml 10ml	Allergy, insect bite	Every 8 hours
Fenistil Gel	All	-	Allergy, insect bite	Every 8 hours
Panadol Tab (500mg)	12 and above	1-2 tablets	Pain, Fever	Repeat after 4 - 6 hours
Saline Nasal Spray/ Drop	All	1 Puff/ Drop in each Nostril	Blocked nose	As required
Reparil Anti-inflammatory Gel	All	-	Muscular trauma/ swelling	Once daily
Optrex Eye Wash	As per instructions	Sand/ Dirt in Eyes	-	As required

As the parent/guardian of ______________________________ (Child's full name),

Born on ____________________ (date of birth).

I have read and understood the list of the medications or solutions used at the School.

I consent to my child being given the above medication should it be considered necessary.
In the event of an emergency, I consent for my child to be taken to a doctor or hospital for diagnosis and treatment.

Name of parent ______________________________

Signature ____________________ Date ____________________

Emergency number ______________________________

If your child is unable to use any of these medications, please contact the School Nurse to discuss the use of an alternative.