The International School
of Choueifat - Dream City

Medical Form

Upon registration, all parents are asked to complete the medical form and return it to the school clinic where it will be kept in your child's medical file.

It is our policy to take all steps within our power to prevent personal injury and health hazards. We fully recognize our responsibilities as far as is reasonably practicable to extend this protection to students and members of the general public from foreseeable risks.

The School Clinic

The school clinic is staffed by fully qualified medical staff who are available in the clinic Sunday to Thursday, from 7:30 a.m. to 3:10 p.m. Students who are medically unfit should stay at home, and students who feel sick during the day may report to the school doctor. All medicines and prescribed drugs must be registered with the school doctor.

If your child is to be administered a medication from your doctor during school hours, it will be given to the school clinic first thing in the morning, with an accompanying letter from the parents or doctor. It can then be collected from the clinic before going home. Please clearly write the child's name, class, time, and dose of the medication. Medicines are not to be kept with children. Students, who are using the school transportation, can leave their medicines with the bus assistants.

School Vaccinations

In accordance with the Kurdistan government's polio vaccination program, a medical team is to visit the school giving both initial and booster vaccinations to those students (under five years of age) who have not been immunized against polio or require a booster, and who, with their parents consent, wish to receive it. Before the assigned date, parents will receive a form in which they indicate their decision as to whether or not they wish their child to be vaccinated at that time.

Guidance and Counseling

The school counseling services constitute part of the duties of the following personnel:

- The Head Supervisor
- The Academic Quality Controllers
- The Student Life Coordinator
- The Director

All students are free to, outside of class time, meet with any of the above people to discuss school or personal matters. It is the nature of the academic administrators' daily tasks that they willingly provide counseling to all their students as and when needed. It is this school's philosophy, and that of SABIS® Network schools generally, that it is the duty of all our professional staff to talk to students and to guide them not only academically, but also pastorally.

I Mr./Mrs _____, parent of the student _____, hereby certify that the information provided in this form is true and assume responsibility for any missing health-related information (illness and/or allergy), and I shall be responsible for and shall release and indemnify _____, its employees, from and against all liability arising from all illnesses or allergies my child has, and the consequences that might result.

I understand that any false or misleading information or significant omissions may entitle the school to reconsider my child's attendance at school. I agree to immediately notify the school should any illnesses develop.

Family	First Name	Middle Name	Date of Birth

Please complete the following details:
(For all parts of this form, if you answer 'yes' please give details.)

1. Vaccination/Immunization

Please indicate if your child has received the following vaccinations. The date is very important.

Vaccination		Yes	Date (Day/Month/Year)
BCG (against TB)	السلّ (الدرن)		/ /
Cholera	كوليرا		/ /
Diphtheria	خانوق		/ /
MMR (measles, mumps, rubella)	حصبة (حصبة المانية، أبو كعب)		/ /
Polio	شلل الأطفال		/ /
Chicken Pox	جدري الماء		/ /
Tetanus	الكزاز		/ /
Typhoid	التيفوئيد		/ /
Whooping Cough	السعال الديكي		/ /
Yellow Fever	الحمّى الصفراء		/ /
Hepatitis A	التهاب الكبد الوبائي A		/ /
Hepatitis B	التهاب الكبد الوبائي B		/ /

2. Is your child presently on any form of medication?

Yes ◯ No ◯

If yes, please specify. _____

3. Did your child have any major operations?

Yes ◯ No ◯

If yes, please specify. _____

_____

_____

4. Does your child presently suffer from any of the following?

Disease	Yes	No	Type
Bronchial Asthma الربو الصدري			
Diabetes السكري			
Epilepsy داء الصرع			
Allergy (If yes, please indicate the type.) حساسية			
Anaemia (If yes, please indicate the type.) فقر الدم			
Other (If yes, please specify.)			

5. Has your child previously suffered from any major medical problem?

Yes ◯ No ◯

If yes, please specify. _____

_____

_____

6. Does your child suffer from any of the following? If yes, please provide details.

Problems with Eyesight _____

_____

Yes ◯ No ◯

Hearing Impaired _____

_____

Yes ◯ No ◯

Heart Issues _____

_____

Yes ◯ No ◯

Speech Problem _____

_____

Yes ◯ No ◯

Name: _____ **الإسم:**

Signature: _____ **التوقيع:**

Date: _____ **التاريخ:**

(Day/Month/Year)