PSI SCHOOL STUDENTS HEALTH CONDITIONS FORM (2019-2020)

Nurturing Excellence

Section 1 should be mail merged by the school.
Parents: Please fill Section 2.
Doctors: Please fill Section 3 and Section 4.

Dear Parents,
In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you which will also be helpful to the health care provider when he or she completes the medical evaluation. We therefore hope that you fill in the below form to provide us with the needed information about your child's health condition.

SECTION 1 Student Details

Student Name: Current Grade:

Student ID Number: Student Age:

SECTION 2 Parent Consent

(For Parents Use)

Parents Details:

Family Name: _____

Father's Name: _____

Contact Number: ☐☐☐☐☐☐☐☐

Mother's Name: _____

Contact Number: ☐☐☐☐☐☐☐☐

Emergency Contact:

Name: _____

Contact Number: ☐☐☐☐☐☐☐☐

I hereby give PSI School permission to:

Administer first aid to my son/daughter Yes ☐ No ☐

Send my son-daughter to hospital in case of emergency Yes ☐ No ☐

Administer any medications, as necessary, to my son/daughter Yes ☐ No ☐

Signature: ☐

SECTION 3 | Health Details

(for Doctors Use)

Student Height: ☐☐☐ cm Student Weight: ☐☐ kg

Does the child suffer from any of the following?

Condition	No	Yes, please specify		*Medication	Comments
Allergies (food, insects, drugs, latex)					
Allergies (seasonal)					
Asthma or breathing problems					
Diabetes		Type 1	Type 2		
Behavioral problems					
Chicken pox					
Blood Pressure					
Epilepsy					
Heart Disease					
Hearing problems or deafness					
Speech problems					
Surgery					
Vision problems					
Attention Deficit/Hyperactivity Disorder					
Epistaxis					
Diptheria					
Mumps					
Measles					
Pertussis					

***Any medication listed must be Stored and Administered by the School Nurse.**

Describe any other important health condition concerning your child.

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly.

_____

Is your child able to participate in physical education? _____

Your child blood type? _____

SECTION 4 | Authority Details

(For Doctors Use)

Dr. Full Name: _____

Dr. Signature: ☐ **Date:** ☐☐☐☐☐☐ (D D M M Y Y)

Clinic Stamp: ☐

Address: 46, AlKhudari street (810),Bin Dirham (25), AlMansoura Area P.O Box 47021 I Doha I Qatar.
Contact: 00974-4032 2422, 00974-7707 8282 **Email:** info@psisd.com.qa
Website: www.psisd.com.qa