Medical History Form (National oral health survey)

Dear Parent/legally authorized representative

Kindly fill this form about the medical history of your son/ daughter by answering **Yes** or **No.**

If any answers is yes, please provide us with dates & details, answers should be as accurate as possible. The student's health is our priority.

Child data:

Child name: …… Gender: Boy ☐ Girl ☐

Nationality: ……Date of birth: …… School: ……..

Parent/ legally authorized representative's name: …… Relation to student: ……

Parent/legally authorized representative contact:

Emirate: …… City: ……

Home phone No: …… Mobile No 1: …… Mobile No 2: ……

No.	Health concerns	Yes	No	Comments
1	Does your child have any allergy or sensitivity to **medications/ food/ …, etc., please** mention it if any …….?			
2	Does your child suffer from any cardiac problems?			
3	Is your child Diabetic?			
4	Does your child have hypertension?			
5	Is your child asthmatic?			
6	Does your child suffer from any renal problems?			
7	Did your child suffer previously from urinary tract infections?			
8	Does your child suffer from epilepsy/ seizures?			
9	Is your child suffering from G6PD?			
10	Does your child have any chronic blood diseases? (Thalassemia, Anemia, Hemophilia …. etc.)			
11	Does your child have any eye (Ophthalmology) problems (visual disturbances)?			
12	Any previous surgical procedures done under General anesthesia?			

Is there any other medical condition that we should know about your child? ……..

Parent/legally authorized representative Signature: …… **Date:** ……

School Nurse Signature: …… **Date:** ……