

Public Health Protection Department- School Health Section

Student Medical Form

Student

こちらへは貼らずに

Photo

学校へ顔写真を2枚ご提出ください

Dear Parent/ Guardian of the Student:

Please fill the following form accurately to ensure maintaining and monitoring your child's health and wellbeing during the school year

School Information	
School Name: Japanese School	Grade: 学年 Section: .....
Student Information	
Student Full Name: 生徒氏名	Gender: 性別
Date of Birth: 誕生日 日/月/年	Nationality: 国籍
Parent or Legal Guardian Name: 保護者氏名	Relationship: 生徒との関係
Mobile Number (1): 携帯番号	Mobile Number (2): 携帯番号その2
E-Mail: メールアドレス	Emirate: Dubai
In case of Emergency and we are unable to reach the parent/guardian, the following person can be contacted:	
Name: 緊急時の連絡先	Relationship: 関係 Mobile Number: 緊急先の携帯番号

Required Attachments			
Student's Emirates ID Copy	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	ID Number: エミレーツIDカード番号 未取得の場合空欄のままです 提出書類に含まれているエミレーツIDのコピーのことです
Student's Passport Copy	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	提出書類に含まれているパスポートコピーのことです
Original Vaccination Card or Updated Copy	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	提出書類に含まれている 母子手帳の予防接種履歴のコピーのことです
Health Card Copy (if any)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Health Card Number: 特に記載しなくて構いません
Health Insurance Card Copy (if any)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	各ご家庭で加入されている医療保険のことです ご提出は不要です

Student Medical History				
Health Problem		Yes	No	Comments
1	Does the student suffer from any allergy to medicine, food, dust, etc.? アレルギー疾患 If yes, please specify in comments			
2	Does the student suffer from any Cardiovascular problem? 心臓疾患			
3	Does the student suffer from Diabetes? 糖尿病			
4	Does the student suffer from Hypertension? 高血圧			
5	Does the student suffer from Bronchial Asthma? 気管支炎 喘息			

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6	Does the student suffer from any Renal Problem? 腎臓疾患			
7	Does the student suffer from Epilepsy or Convulsion seizures? てんかん発作			
8	Does the student suffer from Epistaxis? 鼻血			
9	Does the student suffer from Hemolytic Anemia, type G6PD? 溶血性貧血			
10	Does the student suffer from any Hereditary Blood Disease (e.g. Thalassemia, sickle cell anemia, Hemophilia)? If yes, please specify in comments 遺伝性血液疾患			
11	Does the student suffer from any Skin Problem? 皮膚疾患			
12	Does the student suffer from any Eye problem (Myopia, Hyperopia...)? If yes, please specify in comments 目の疾患			
13	Does the student suffer from any Hearing problem? 聴覚障害			
14	Does the student use any medical aid device? If yes, please specify the device details in comments 医療補助装置の使用歴			
15	Did the student undergo any surgery in the past? If yes, please specify the details in comments 手術歴			
16	Was the student ever hospitalized? If yes, please specify the reasons in comments 入院歴			
17	Does the student have any health condition that could weaken the immune system such as Cancer (Blood cancer, Lymphoma), or an organ transplant? If yes, please specify in comments 血液のがん、リンパ腫、免疫低下をもたらすもの、臓器移植			
18	Did the student get any blood, antibodies or plasma transfusion in the past? 輸血歴			
19	Did the student suffer from any of the following diseases: (Mumps, Measles, Diphtheria, Pertussis, Chickenpox, Tuberculosis), If yes, please specify details in comments おたふくかぜ、麻疹、ジフテリア、百日咳、水ぼうそう、結核			
20	Did the student suffer from Viral Hepatitis? ウイルス性疾患			
21	Did the student suffer from Poliomyelitis (Infantile paralysis infection)? ポリオ			
22	Does the student suffer from any Mental or Behavioral Problem? If yes, please specify in comments 精神疾患、行動障害			
23	Does the student suffer from any other Problem or disease not mentioned here? If yes, please specify in comments その他			

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**If the student suffer/suffered from any of the health problems mentioned or not mentioned above, please answer the following questions** 上記で該当するものが1つでもある場合、または該当するものがない場合でも、現在服用している薬剤などあればご記入下さい。

**Medications or Treatments taken continuously** 継続して服用している薬  
**Medicine Name:** ..... 薬剤名 **Dosage:** ..... 服用量

**Emergency Medications** 救急で服用する薬  
**Medicine Name:** ..... 薬剤名 **Dosage:** ..... 服用量

**Any treating Doctor instructions on Student's nutrition** 医療中の医師による栄養指導  
 .....

**Any treating Doctor instructions on Student's physical activity and exercise** 医療中の医師による身体活動の指導  
 .....

**Any treating Doctor instructions for Student's School Doctor/Nurse to apply during the school day**  
 .....  
在校時において、医師、看護師に知らせておきたい事項

**Family Medical History** 家族の病歴

	Health Problem	Yes	No	Comments
1	Any Cardiovascular problem and Hypertension	心血管疾患、高血圧		
2	Diabetes <small>糖尿病</small>			
3	Any Hereditary Blood Disease (e. g. Thalassaemia, sickle cell anemia, Hemophilia)	遺伝性血液疾患 (サラセミア、鎌状赤血球症、血友病など)		
4	Any type of Cancer <small>がん</small>			
5	Any Immune System problem <small>免疫疾患</small>			
6	Any Mental Health problem <small>精神疾患</small>			
7	Others, please specify in comments <small>その他</small>			

**Parent/ Guardian approval and verification for the above mentioned information**

**Parent /Guardian Name:** ..... 保護者氏名 **Relationship:** ..... 生徒との関係

**Parent/ Guardian Signature:** ..... 保護者のサイン **Date:** ..... 記入日

**Notes**

- Please attach medical reports about the Student's health problem, if any
- It is the responsibility of the Student's Parent/ Guardian to inform the school clinic of any changes in the Student's health status and submit medical reports accordingly to update the Student's Medical Record at School.

Please contact the School Doctor/Nurse if there are any queries

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