GOVERNMENT OF DUBAI

DUBAI HEALTH AUTHORITY

NORTH AMERICAN INTERNATIONAL SCHOOL, DUBAI

CONSENT FOR IMMUNIZATION

CHILD NAME : _____SEX: _____

DATE OF BIRTH : _____NATIONALITY:_____

GRADE & DIVISION: _____

ADDRESS: _____

FATHER'S NAME: _____ Contact Number: _____

MOTHER'S NAME: _____ Contact Number: _____

PLEASE TICK (√)

☐ I give the consent for the immunization of my child.

☐ I don't agree for immunization of my child.

DEAR PARENTS,
Please provide the following information to update your child school health record and send **PHOTOCOPY** of his/ her **ORIGINAL IMMUNIZATION CARD.**

CHILD HISTORY OF ILLNESS:
Please tick (√) appropriately, if yes, Specify Month/ Year of illness,

INFECTIOUS DISEASE	YES	NO	NON INFECTIOUS DISEASE	YES	NO
Diphtheria			Accidents		
Dysentery			Allergies		
Infective Hepatitis			Bronchial Asthma		
Measles			Congenital Heart Disease		
Mumps			Diabetes Mellitus		
Poliomyelitis			Epilepsy		
Rubella			G6PD(Glucose6PhosphateDehydrogenase deficiency)		
Scarlet Fever			Rheumatic Fever		
Tuberculosis			Thalassemia		
Whooping Cough			Surgical Operation		
Chicken pox					

HISTORY OF:
Blood transfusion: ☐ No ☐ Yes, Frequency: _____
Hospitalization: ☐ No ☐ Yes, Reason: _____
Family History: ☐ Diabetes ☐ Hypertension ☐ Mental disorder ☐ Stroke
☐ Tuberculosis Others, Specify: _____

Parent/ Guardian signature: _____ Date: _____

Licensed School Nurse Name & Signature: _____