Al Quaim Islamic Mission
Essential Information:
MEDICAL FORM

Name: ____ D.O.B.: _________________ Male / Female

Email Address:____

Emergency Contact No's (1) _____________________________________ / _______________________________

(2) _____________________________________ / ________________________________

Doctors Name and Address: ____

____

Medical Conditions ☐ None

☐ Allergy to penicillin
☐ Allergy to dust
☐ Allergy to egg white
☐ Allergy to nuts
☐ Asthma
☐ Diabetes
☐ Multiple sclerosis
☐ Tuberculosis
☐ Heart condition
☐ Citrus fruits allergy
☐ Allergy to pulses
☐ Allergy to steroids
☐ Arthritis
☐ Eczema
☐ Epilepsy
☐ Hayfever
☐ Hearing impairment
☐ Vision impairment
☐ Student has Epipen
☐ Seafood allergy

Other: Please specify ____

Self medicates: ☐ no ☐ yes

Self medicates with:
☐ Inhaler
☐ Tablets
☐ Epipen

Acceptable forms of pain relief:

☐ Nurofen / Ibuprofen
☐ Aspirin
☐ Calpol
☐ Paracetamol
☐ Flu relief

I agree to my son / daughter ________________________ receiving medication as instructed and any urgent dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

I undertake to inform the Committee of any medical or contact changes after the date below, so the safety of my child is not compromised.

Signed: ____ Date: ________________________
(parent / guardian)

If there is any other relevant information for your child which would be helpful to the Mission please provide details below: