COMPASS INTERNATIONAL SCHOOL
A NORD ANGLIA EDUCATION SCHOOL

ACADEMIC YEAR
2026-27

Medical and Consent Form

Student Name: ☐ Gender: ☐

Date of Birth: ☐ Age: ☐ Class: ☐ Teacher: ☐

Blood Type (If known): ☐

Parent or Guardian Information

Parent Name: ☐ Relationship: ☐

Telephone: ☐ Mobile: ☐ Email Address: ☐

Parent Name: ☐ Relationship: ☐

Telephone: ☐ Mobile: ☐ Email Address: ☐

Emergency Contacts

Minimum one, two requested.

Name **(Other than a parent or guardian)**: ☐

Relationship: ☐ Email Address: ☐

Daytime Telephone: ☐ Mobile: ☐

Name **(Other than a parent or guardian)**: ☐

Relationship: ☐ Email Address: ☐

Daytime Telephone: ☐ Mobile: ☐

Medical and Dietary Information

Please indicate with a tick if your child suffers any of the following:

- ○ 1. Allergies
- ○ 2. Asthma
- ○ 3. Diabetes
- ○ 4. Heart Problem
- ○ 5. Epilepsy
- ○ 6. Seizures of any type
- ○ 7. Migraine
- ○ 8. Food Intolerance
- ○ 9. Others
- ○ NONE
- ○ I certify that there are not known medical problems with my child

If you have ticked any of the above, please specify and ***attach the medical report***:

☐

Medications

Is your child taking daily chronic medication? ○ YES ○ NO

Does your child require emergency/rescue medication? ○ YES ○ NO

Please Turn Over

If you have ticked yes, please complete the below:

Name of medication	Daily timing and dosage

All medication provided to the school must come with supporting prescriptions and medical report in English. This will include pupil's name, diagnosis, dosage, time of administration and Doctor's signature. Medication will be kept safe in the clinic, where our School Nurse will clearly label it with all instructions needed for her or any other aider to administer when necessary. Students are not allowed to carry their own medication.

***Please attach your child's prescription and medical report supporting the above.

Medications will not be administered or accepted without medical report and medical prescription.

Vaccination

As part of our ongoing efforts to maintain accurate health records for all students, and in line with the recent directive from the Ministry of Public Health (MOPH) regarding student immunization, we kindly ask for your cooperation.

The MOPH requires all schools to ensure that each student has an up-to-date vaccination record on file, confirming they are protected against all mandated vaccines as per the Qatar National Immunization Schedule.

Please confirm:
Is your child up to date with all the vaccinations according to the approved Qatar National Vaccination Program? ◯ YES ◯ NO

If yes, **please attach a copy of your child's vaccination card.**
You may also submit a vaccination card from your home country, which will be accepted temporarily until your child is registered and seen at a local Health Center.

If no, please ensure your child receives the required vaccinations and submit an updated vaccination card as soon as possible.

Consent for Emergency Medical Treatment

I understand that information given above will be shared with appropriate school staff to provide for the health and safety of my child.

*****Please ensure that you attach the most updated vaccination card along with any Medical Reports or Prescription.**

◯ **I certify that all information in this document is correct and current of today.**

◯ **In the event of an emergency, if parents/guardians cannot be reached, I authorise the school nurse or designated trained staff to administer necessary emergency medication and seek urgent medical treatment for my child as deemed appropriate.**

Parent/Guardian ____________________

Signature: ____________________ **Date:** ____________________