SORBONNE UNIVERSITY ABU DHABI

هارلي ستريت ميديكال سنتر
HARLEY STREET MEDICAL CENTRE

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STUDENT MEDICAL RECORD

Part 1

Please complete this Health Information Form and return it to our University Nurses. The information provided will remain confidential for all staff. Information shall be filled in by Student or Parent.

Note: In the case of patients below 18 y/o, consent must be signed by a parent or a guardian.

Student's Banner ID:	**Gender:** ☐ Male ☐ Female	**Date of Birth:**
Student's Full Name:		
Major:	**Year level:**	**Mobile #:**
Emirates ID/ Passport #:	**Residence address:**	**Nationality:**
Do you have Current Medical condition?	☐ Yes	☐ No
In case of Emergency, please contact:	**Mobile #:**	
Student Signature/ substitute consent giver if student is below 18 y/o:	**Date:**	

Part 2

Tick all boxes that apply. Student should provide the university with any medication, special food, or equipment that he/she will require while in the university. If a student has an Individual Health Care Plan, necessary medical information and authorization forms must be provided to the Registrations Department. For minor students below age18, the Parent or Guardian is responsible for providing the necessary information.

1. ALLERGIES

Allergy Type:

☐ Food Please specify:	☐ Medication Please specify:	☐ Bee Stings
☐ Others:		

Reactions:

☐ Coughing	☐ Hives	☐ Rash
☐ Difficulty Breathing	☐ Local Swelling	☐ Wheezing
☐ Generalized Swelling	☐ Nausea	☐ Other

Currently prescribed treatments to be used *IN UNIVERSITY*

☐ Oral Antihistamine (Benadryl, etc)	☐ EpiPen
☐ Others:	

Consent to share food allergy information with the University Canteen personnel:
☐ Yes – The allergy information can be shared to the canteen personnel by the University Nurse
☐ No – The allergy information cannot be shared to the canteen personnel by the University Nurse

2. ASTHMA OR REACTIVE AIRWAY DISEASE

Triggers:

☐ Exercise Please specify:	☐ Environmental Please specify:
☐ Others:	

Symptoms or Reactions:

☐ Chest tightness, discomfort or pain	☐ Difficulty breathing	☐ Itchy throat, tightness orsoreness
☐ Coughing	☐ Hoarseness	☐ Wheezing
☐ Others:		

Currently prescribed treatments to be used ***IN UNIVERSITY***

☐ Inhalers	☐ Oral Antihistamines	☐ Oral Steroids
☐ Nebulizer	☐ Oral bronchodilator	☐ Peak Flow Monitoring
☐ Others:		
☐ Date of last hospitalization related to asthma:		

3. DIABETES

Currently prescribed treatments to be used ***IN UNIVERSITY***

☐ Insulin	☐ Syringe	☐ Pen
☐ Pump	☐ Blood SugarTesting	☐ Glucagon
☐ Oral Medications Please List Oral Medications:		
☐ Is special scheduling of lunch or Physical Education required?	☐ Yes	☐ No

4. SEIZURE DISORDER

Type of seizure:

☐ Absence (staring,unresponsive)	☐ Complex Partial	☐ Generalized Tonic-Clonic grand mal, convulsive)
☐ Others Please explain:		
☐ Medications needed ***IN UNIVERSITY?***	☐ Yes	☐ No
☐ Please List Medications:		
☐ Date of last seizure:	☐ Length of seizure:	

5. OTHER HEALTH CONDITIONS: (please see PART 3)

☐ Cancer	☐ Heart Conditions Please specify:	☐ Hemophilia
☐ Physical disability Please specify:	☐ Respiratory Please specify:	☐ Other Please provide details:
☐ Medications needed ***IN UNIVERSITY***?	☐ Yes	☐ No

Please List Medications:		
Special procedures required in school? Please provide details:	☐ Yes	☐ No

Vision Conditions:

☐ Contacts	☐ Glasses	☐ Other:

Hearing Conditions:

☐ Hearing Aid(s)	☐ Others:

Part 3

Additional Information: Please complete below table.

Illnesses	No	Yes/Date	Conditions	No	Yes/Date/Details
• Chicken Pox			• Major Illness/Hospitalization (including surgery)		
• Diphtheria					
• Dysentery					
• Infective Hepatitis			• Significant Injury/Accident		
• Measles			• Recurrent Tonsillitis, Sore Throats, Ear Infections		
• Meningitis					
• Mumps			• Frequent Gastric Problems, StomachAches		
• Poliomyelitis					
• Rheumatic Fever			• Blood Disorders, G6PD Deficient		
• Rubella (German • Measles)			• Frequent Headaches, Concentration Difficulties		
• Scarlet Fever					
• Tuberculosis			• Emotional/Behavioral • Issues, Weight/EatingConcerns		
• Whooping Cough					
• Other:			• ADD, ADHD		
			• Nocturnal Enuresis(bed wetting)		
			• Other:		

MEDICAL CONSENT FORM

Part 4

1. STUDENT/PARENTAL/GUARDIAN CONSENT FOR UNIVERSITY NURSE TO GIVE FIRST AID ASSESSMENT AND TREATMENT

Student Health Information is strictly confidential and will not be shared unless an illness or medical condition requires attention when the student is at university. Please return the completed form to the University Clinic as soon as possible.

The university nurse will attempt to contact guardian/relative of the student should an emergency arise.

☐ **Yes** ☐ No I authorize and empower Sorbonne University - Abu Dhabi Nurse or a University Administrator to make any and all decisions concerning my medical care which may include calling paramedic team for emergency treatment.

Student/Parent/Guardian Name: ____

Student/ Parent/Guardian Signature:____ **Date:** _________________________

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2. STUDENT/PARENTAL/GUARDIAN CONSENT TO ADMINISTER EMERGENCY MEDICATION

I authorize that myself or my son/daughter:

Full Name of Student: ____

Known Allergies: ____

Be given the appropriate non-prescribed medication in the following cases:

1. Administration of Epinephrine in an acute allergic reaction (anaphylactic shock)
2. Administration of Salbutamol Inhaler to control asthmatic symptoms
3. Administration of Oral Glucose for hypoglycemia
4. Administration of Paracetamol to control mild to moderate pain and fever
5. Administration (topical) of Antihistamine Cream for allergic reaction

Any precautions that the University personnel should know?	Any contra-indications that the University personnel should know?
What are possible reactions/side effects?	What should be done in the event of reaction/side effect?
Check appropriate boxes below: ☐ YES – The above medication can be administered by a HAAD Licensed University nurse in accordance with the standards and relevant policies. ☐ NO – The above medication cannot be administered by a HAAD Licensed University Nurse.	

Student/Parent/Guardian Name: ____

Student/ Parent/Guardian Signature: ____ **Date:** _________________________