المـــدرســـة الهنديـــة – العين
INDIAN SCHOOL AL-AIN

Managed by: Governing Council (Al-Ain) Approved by AbuDhabi Department of Education & Knowledge (ADEK), ADEK No: 9161 and Affiliated to the Central Board of Secondary Education (CBSE), New Delhi, India, Affiliation No: 6630011 Member – Council of CBSE Affiliated Schools in the Gulf

Ref: ISA/CIR/2021-2022/21 Dated: 21/09/2021

Dear Parent (s)
Greetings!

We wish to inform you that all students of **Grade I** will be vaccinated as per the directives and schedule of SEHA. Date and place of vaccination will be informed in due course of time.

Kindly complete the following documents attached

1) Pre vaccination checklist

2) Vaccination consent form

Please attach vaccination card copy (birth to 5 years) and emirates ID copy of your ward (both sides). If emirates ID is under process kindly attach passport copy of your ward.

The scanned copies can be sent by mail to isa1@isalain.org

Or

Submit to **Security Staff** at the main entrance between 8 am and 5 pm.

Last date of Submission: **Monday, 27th September 2021**

Thanking you for your co–operation.
Yours Faithfully

Neelam Upadhyay
Principal

خدمـات الصحـة المدرسيـة
School Health Services
الخدمـات العلاجيـة الخارجيـة
Ambulatory Healthcare Services

Pre Vaccination Checklist

Academic Year 20…….. / 20……..

Student's name: ______________________________	Gender: Male Female	Date of birth: ______/______/______ dd mm yy
School: _____________________________________	Grade: _____	Section: _____________

- To ensure safe vaccination, the nurse requires information about your son/daughter's health status. Please review and complete the following checklist and return to the school nurse prior to vaccinating your child.
- Please note: Answering Yes to any question(s) does not necessarily mean that the student can't be vaccinated at the school clinic unless it is contraindicated.
- The vaccination checklist will be distributed at the beginning of the academic year. Please inform the school nurse of any change in the student's health status during the academic year as it might be a contraindication for vaccination.

#	Category	Yes	No
1	Does the student have any allergies to medication, food or vaccination, Others specify: ……		
2	Has the student had a serious reaction to a vaccine in the past? Please specify: ……		
3	Has the student had a seizure or brain (neurological) problem?		
4	Does the student have cancer, leukemia, AIDS, organ transplant or any other immune system problem? Specify …………………………………………………………………………………………………		
5	Do any household member / relative living in the same house have cancer, leukemia, AIDS, organ transplant or any other immune system problem? If yes specify ……………………………		
6	Has the student taken cortisone, prednisone, other steroids, or anticancer drugs such as chemotherapy or radiotherapy in the past 3 months? If yes, add the date …………………………		
7	Has the student received a transfusion of blood or blood products, or received a medicine called immune (gamma) globulin in the past year? ………………………………………………………		
8	Does the student have a past history of Guillain-Barre syndrome/has a chronic illness or has a bleeding disorder? Please specify: …………………………………………………………………………		
9	Has the student received any vaccinations in the last month? If yes please specify Name of the vaccine taken ……………………………………………………………………………………… Date given ……		
10	Is the student repeating the same class of last academic year? ………………………………………		
11	**For Grades 8 and 11 females:** Is the student planning to get married during the current academic year or summer vacation? (as **HPV vaccine is contraindicated in pregnancy**)		

Note:
- Attach a copy of the pre-school vaccination card
- Attach a medical report if vaccine is contraindicated
- Inform the school nurse about any change regarding student's health any time during the academic year.
- Attach a copy of UAE ID both sides.

Name of Parent/ Guardian: ____________________ Contact number: _____________

Parent/ Guardian Signature: ___________________ Date: ____________

By selecting the "Agree" button, you are signing this Consent electronically. You agree your electronic signature is the legal equivalent of your manual signature on this checklist

*If any further queries, please contact the school nurse.

School Health Services / خدمات الصحة المدرسية
Ambulatory Healthcare Services / الخدمات العلاجية الخارجية

نموذج الموافقة على إعطاء التطعيمات المدرسية
School age Immunization Consent form

Student's Name:_______________________________________ اسم الطالب/ة:_______________________________________

School: _________________________Grade:______ Section:____ المدرسة:_______________________ الصف:_______ الشعبة:_____

Student No.: ____________________ رقم الطالب المدرسي: _________________

DOB:_________________ Gender: Male Female تاريخ الميلاد:_________________ الجنس : ذكر أنثى

Nationality: ____ الجنسية:____

The School Health Services / Ambulatory Healthcare Services-SEHA will provide the students with the following vaccines at schools as booster doses for the pre – school vaccination national program as recommended by Department of Health (DOH)	سوف تقوم ادارة الصحة المدرسية / الخدمات العلاجية الخارجية – صحة بإعطاء التطعيمات التالية للطلبة. وتعتبر هذه التطعيمات جرعات منشطة ومكملة لبرنامج التطعيم الوطني حسب التوصيات المعمول بها من دائرة الصحة في أبوظبي وذلك حسب الجدول التالي.

الصف Grade	طريقة إعطاء اللقاح Administration route	التطعيم Vaccine
الأول الإبتدائي **Grade 1**	حقنة تحت الجلد Subcutaneous injection	**الحصبة، الحصبة الألمانية، النكاف** **Measles, Mumps, Rubella (MMR)**
	حقنة بالعضل Intramuscular Injection	**الدفتيريا والتيتانوس والسعال الديكي وشلل الأطفال (حسب عمر الطالب/ة)** **Diphtheria, Tetanus, Pertussis and Polio** (DTaP-IPV for students younger than 7 years/ Tdap for students 7 years and above)
	حقنة تحت الجلد Subcutaneous injection	**الجديري المائي جرعة أو جرعتين** **Varicella one or two doses**
الثامن (إناث) **Grade 8 (Female)**	حقنة بالعضل Intramuscular Injection	**تطعيم الوقاية من سرطان عنق الرحم/ HPV9** جرعتان للإناث أصغر من 15 سنة من العمر Two doses for females younger than 15 years of age ثلاث جرعات للإناث 15 سنة من العمر وما فوق Three doses for females 15 years of age and above
الحادي عشر (ذكور وإناث) **Grade 11** **(Male & Female)**	حقنة بالعضل Intramuscular Injection	**التيتانوس والدفتيريا والسعال الديكي** **Tetanus, Diphtheria, Pertussis (Tdap)**
	حقنة بالعضل Intramuscular Injection	**تطعيم المكورات السحائية (الرباعي)** **Meningococcal vaccine (MCV4)**
الحادي عشر (إناث) **Grade 11 (Female)**	حقنة بالعضل Intramuscular Injection	**تطعيم الوقاية من سرطان عنق الرحم / HPV4** Three doses / ثلاث جرعات

I agree with my child being vaccinated	**أوافق على إعطاء إبني / إبنتي هذا التطعيم**
I also authorize the AHS/SHS vaccination nurse to administer epinephrine in case of anaphylactic reaction after vaccination as recommended by DOH	كما انني أسمح لممرض/ة التطعيم (الصحة المدرسية/ الخدمات العلاجية الخارجية) بإعطاء إبني/ إبنتي الابينيفرين في حالة الحساسية المفرطة الناتجة عن التطعيم كما هو موصى به من قبل دائرة الصحة/ أبو ظبي
I disagree with my child being vaccinated because: My child has been vaccinated before with the above marked booster dose; (please send a document proving that). My child has a medical condition which prevents him / her from taking the vaccination now (please send a letter written by you or doctor explaining the medical condition to the school nurse) Others (Specify) ---	**لا اوافق على اعطاء ابني / ابنتي التطعيم لأن:** إبني / إبنتي قد تم تطعيمه سابقاً بالجرعة المنشطة المشار اليها أعلاه (يرجى إرسال ما يثبت ذلك إلى عيادة المدرسة) لوجود موانع طبية للتطعيم يرجى إرسال إقرار من قبلكم او من قبل الطبيب المعالج إلى ممرض / ممرضة الصحة المدرسية) أخرى حد ---
I understand that the medical record is a confidential document. Reporting of medical information to other entities is subject to DOH data management and standards requirements policy.	إن الملف الصحي وثيقة سرية. يخضع الإبلاغ عن المعلومات الطبية إلى الجهات الأخرى لسياسة ادارة البيانات ومتطلبات دائرة الصحة في امارة أبوظبي.
Parent's / Guardian's Name: .... Signature: .... Relation: .... Date: .... Tel. #:	اسم ولي الأمر / الوصي الشرعي:... التوقيع:..............................صلة القرابة:..................... التاريخ: .... رقم الهاتف............................
By selecting the "I Accept" button, you are signing this Consent electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Consent.	بتحديد الزر "أوافق" ، فإنك تقوم بتوقيع هذه الموافقة إلكترونيًا. أنت توافق على أن توقيعك الإلكتروني هو المعادل القانوني لتوقيعك اليدوي على هذه الموافقة.

If any further queries, please contact the school nurse. في حال وجود أي إستفسار الرجاء الإتصال بممرض/ة المدرسة

Nurse's Name -اسم الممرض/ة: .... الرقم الوظيفي/ID: ....