



المدرسة الهندية – العين  
**INDIAN SCHOOL AL-AIN**

Managed by: Governing Council (Al-Ain) Approved by Abu Dhabi 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/2020-2021/21

Dated: 21/09/2021

Dear Parent (s)  
Greetings!

We wish to inform you that all students of **Grade 8 (Only Girls)** 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 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 [isa8@isalain.org](mailto:isa8@isalain.org)

Or

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

Last date of Submission: **Monday, 27<sup>th</sup> September 2021**

Thanking you for your co-operation.

Yours Faithfully

Neelam Upadhyay  
Principal

**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	<b>For Grades 8 and 11 females:</b> Is the student planning to get married during the current academic year or summer vacation? (as <b>HPV vaccine is contraindicated in pregnancy</b> )		

- 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.

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 ومكاملة لبرنامج التطعيم الوطني حسب التوصيات المعمول بها من دائرة الصحة في أبوظبي وذلك حسب الجدول التالي.

Grade	Administration route	Vaccine
Grade 1	Subcutaneous injection	الحصبة، الحصبة الألمانية، النكاف Measles, Mumps, Rubella (MMR)
	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)
	Subcutaneous injection	الجديري المائي جرعة أو جرعتين Varicella one or two doses
Grade 8 (Female)	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
Grade 11 (Male & Female)	Intramuscular Injection	التيتانوس والدفتيريا والسعال الديكي Tetanus, Diphtheria, Pertussis (Tdap)
	Intramuscular Injection	تطعيم المكورات السحائية (الرباعي) Meningococcal vaccine (MCV4)
Grade 11 (Female)	Intramuscular Injection	تطعيم الوقاية من سرطان عنق الرحم / HPV4 ثلاث جرعات / Three doses

<b>I agree with my child being vaccinated</b> I also authorize the AHS/SHS vaccination nurse to administer epinephrine in case of anaphylactic reaction after vaccination as recommended by DOH	<b>أوافق على إعطاء ابني / ابنتي هذا التطعيم</b> كما انني أسمح لممرض/ة التطعيم (الصحة المدرسية/ الخدمات العلاجية الخارجية) بإعطاء ابني/ ابنتي الأبينيفرين في حالة الحساسية المفرطة الناتجة عن التطعيم كما هو موصى به من قبل دائرة الصحة/ أبوظبي
<b>I disagree with my child being vaccinated because:</b> 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) _____	<b>لا اوافق على اعطاء ابني / ابنتي التطعيم لأن:</b> ابني / ابنتي قد تم تطعيمه سابقاً بالجرعة المنشطة المشار إليها 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 اماره 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 إلكترونياً. أنت توافق على أن توقيعك الإلكتروني هو المعادل القانوني لتوقيعك اليدوي على هذه الموافقة.

If any further queries, please contact the school nurse.  
 Nurse's Name: \_\_\_\_\_ اسم الممرض/ة: \_\_\_\_\_

في حال وجود أي إستفسار الرجاء الإتصال بممرض/ة المدرسة  
 ID: \_\_\_\_\_ الرقم الوظيفي/