AUD HEALTH SERVICES

Dear incoming student,

AUD prides itself on offering quality health services. To maintain our standards and fully address the health and medical needs of our students, the AUD Health Center requires that all AUD students submit the Student Health History Form, ***endorsed by a physician***, to the AUD Admissions Office, or to the AUD Health Center.

All health information is confidential, and can be shared with AUD staff in support of a student's best interest at the discretion of the Health Center Director. All student medical records are kept under a locked filing system; they are not released to others without the written consent (Authorization of Health Information Release) of the student or his/her parents. The AUD Health Center personnel are available 24 hours a day to answer any health-related questions and concerns.

Student Health Insurance

Private health insurance covering care in the UAE is mandatory for all AUD sponsored students. Health insurance fees are payable at the time of visa application. (Kindly check AUD Website for further information).

AUD non-sponsored students are required to have and maintain private health insurance covering all UAE care. They may join the AUD-sponsored health insurance plan at the beginning of each semester subject to approval from the insurance company. Insurance fees are subject to change.

Students with Special Medical Condition: Students of Determination

The American University in Dubai aims to guarantee an integrated and inclusive learning experience for students with special needs. It is committed to providing students of determinations with reasonable accommodations and equal access to university programs and activities. Special needs comprise disabilities that limit one or more major life activities and medical issues requiring special and immediate intervention.

Special Needs cases could be Physical, Psychological, or Learning disorder.

The Health Center welcomes and encourages students with special needs to identify themselves and to seek the required support.

Kindly send this form, the completed Health History Form(below), and copy of your medical insurance card, valid in UAE, to the Health Center on: healthcenter@aud.edu

Best wishes for a healthy educational experience at AUD.

Nelly Halabi
Health Center Director

AUTHORIZATION FOR DISCLOSURE OF HEALTH HISTORY INFORMATION

By signing this form, I give permission to the AUD Health Center Director to disclose the content of my health history form. I understand that I have the right to revoke this consent at any time by notifying the AUD Health Center in writing.

Failure to sign this form constitutes non-authorization.

_____ _____

Signature *Date (dd/mm/yy)*

HEALTH HISTORY FORM

*In order for the Health History Form to be approved, it is mandatory that the questionnaire be completed and stamped **by a physician** and that all immunizations are current. This form is to be submitted during registration.*
To the examining physician: Thank you for completing this form.

Student Name **ID #** **Semester**

Gender Male Female **Date of Birth (mm/dd/yy)** **Nationality** **Blood Group**

In Case of Emergency Contact

Contact Name 1 **Contact Name 2**

Mobile # **Mobile #**

E-mail Address **E-mail Address**

Please indicate if the student has any of the following illnesses or conditions. List any medicine the student is currently taking for the condition.

Migraine	Yes	No	Medication
Back Problems	Yes	No	Medication
Blood Pressure	Yes	No	Medication
Psychological Problems: ADD, ADHD, Depression, etc...	Yes	No	Medication
Learning Disorder: Dyslexia, Dyscalculia, etc...	Yes	No	Medication
Neurological Problems	Yes	No	Medication
Anxiety Problems	Yes	No	Medication
Anemia	Yes	No	Medication
Kidney Problems	Yes	No	Medication
Diabetes	Yes	No	Medication
Chest Problems: Asthma	Yes	No	Medication
Jaundice	Yes	No	Medication
Stomach/Gastric Problems	Yes	No	Medication
Heart Problems	Yes	No	Medication
Malaria	Yes	No	Medication
Epilepsy	Yes	No	Medication
Chickenpox	Yes	No	If yes, please state date
Vision Disorder	Yes	No	If yes, please state
Hearing Problem	Yes	No	If yes, please state
Past surgeries	Yes	No	If yes, please state date, name and reason
Medication Allergies	Yes	No	If yes, please state name and type of reaction Medication
Food allergies	Yes	No	If yes, please state name and type of reaction Medication
Environmental allergies *i.e. wasp stings, bites, dust, pollen*	Yes	No	If yes, please state name and type of reaction Medication

Is the applicant on a long-term treatment for any medical condition? Yes, No If yes, please state

Is the applicant suffering from any other illnesses, not listed above? Yes, No If yes, please state

Is the applicant current with immunizations? Yes No If yes, please state last booster:

DT, Polio	Date	MMR	Date
Hep. A	Date	Hep. B	Date
Meningitis	Date	Varicella (Chickenpox)	Date

SARS-CoV-2 Date: 1st dose 2nd dose 3rd dose

Physician Name, Signature & Stamp **Date (dd/mm/yy)**