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. Only the following staff members can discuss the content of medical documents, with the health professionals (as needed): President, Vice President, Provost, Dean of Student Affairs, and Housing Manager (for dorm students). 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 fees with Finance).

AUD non-sponsored students are required to have and maintain private health insurance covering all UAE care. They can 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, Mental, or related to Learning disorders.
The Health Center welcomes and encourages students with special needs to identify themselves and to seek the needed 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 University 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 _____

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