

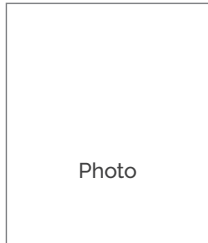


MEDICAL FORM

OFFICE USE

Class:

Date Joined:



CHILD INFORMATION

My Name is:

My Last Name:

My Nickname:

My Birth Date is:

My Gender is:

My Home Phone is:

My Home Address is:

PARENT INFORMATION

All About my Dad

Full Name:

Place of Work:

Nationality:

Mobile Phone:

Work Phone:

Email Address:

All About my Mum

Full Name:

Place of Work:

Nationality:

Mobile Phone:

Work Phone:

Email Address:

PHYSICIAN INFORMATION

Doctor/Physician Name

Clinic/Hospital

Office Phone

Mobile Number

Private Health Insurance Company

Health Insurance Number



MEDICAL INFORMATION

Has your child had or suffered from any of the following illnesses/conditions?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Frequent colds/sinusitis | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hand, Foot and Mouth |

Does your child have any known allergies? Yes No

If yes, please provide additional information or documentation.

Does your child have any special dietary requirements? Yes No

If yes, please provide additional information or documentation.

Does your child have any other medical conditions or receive medical treatment? Yes No

If yes, please provide additional information or documentation.

Are your child's vaccinations fully up to date? Yes No

Has your child been assessed by any specialist such as speech, occupational therapist or any other? Yes No

If yes, please provide additional information or documentation.

Is there any other information relating to your child's health that you feel we might need to know? Yes No

If yes, please provide additional information or documentation.



MEDICAL FORM

PARENTAL CONSENT

Consent for the administration of medication:

In the event that my child develops a fever, pain or allergy, Best Kidz Nursery staff may need to administer medication.

Paracetamol for fever?

Yes

No

Antihistamine for allergy symptoms?

Yes

No

Arnica gel for mild bruising?

Yes

No

Fenistil Gel/Calamine Lotion for bites?

Yes

No

COMMENTS

Others:

If my child is unable to use any of these medications, I will contact the Nurse to discuss the use of an alternative.

Parent Signature: _____

Date: _____

Consent for basic first aid treatment

In the unlikely event of an accident or emergency situation, I give permission for the staff of Best Kidz Nursery to administer first aid to my child whilst at Best Kidz Nursery and if necessary transported to the nearest medical clinic or hospital. I understand that all costs for medical treatment including ambulance or transport fees are the responsibility of the parent.

Parent Signature: _____

Date: _____