



MEDICAL FORM



First Name	Middle Name	Family Name
Date of Birth	Gender	
___/___/___ DD MM YY	Male <input type="radio"/> Female <input type="radio"/>	



Home Address	PO Box	Home Phone
Father`s Name	Father`s Mobile No	Fther`s Work Phone
Mother`s Name	Mother`s Mobile No	Mother`s Work Phone



Physician Name	Clinic / Hospital
Telephone Number	Mobile Number



Insurance Company	Child`s Insurance Number



Has your child had any of the following illnesses or suffer from any of these condition? No

Chicken Pox	Yes <input type="radio"/> <input type="radio"/> No	Frequent colds / Sinusitis	Yes <input type="radio"/> <input type="radio"/> No
Whooping Cough	Yes <input type="radio"/> <input type="radio"/> No	Asthma	Yes <input type="radio"/> <input type="radio"/> No
German Measles (Rubella)	Yes <input type="radio"/> <input type="radio"/> No	Epilepsy	Yes <input type="radio"/> <input type="radio"/> No
Measles	Yes <input type="radio"/> <input type="radio"/> No	Diabetes	Yes <input type="radio"/> <input type="radio"/> No
Mumps	Yes <input type="radio"/> <input type="radio"/> No	Heart Trouble	Yes <input type="radio"/> <input type="radio"/> No
Rheumatic Fever	Yes <input type="radio"/> <input type="radio"/> No	Hepatitis	Yes <input type="radio"/> <input type="radio"/> No
Scarlet Fever	Yes <input type="radio"/> <input type="radio"/> No	Pneumonia	Yes <input type="radio"/> <input type="radio"/> No
Tuberculosis	Yes <input type="radio"/> <input type="radio"/> No	Poliomyelitis	Yes <input type="radio"/> <input type="radio"/> No
Tonsillitis	Yes <input type="radio"/> <input type="radio"/> No		

Does your child have any allergies or food restrictions? Yes No
If yes, please specify:

One Word

Consent For Paracetamol

The nursery will always attempt to contact the parent prior to administering paracetamol. If the nursery cannot contact the parent immediately, your signature below empowers the nursery to administer paracetamol if required

Signature of Parent	Date

I hereby authorize the nursery nurse or any staff qualified in paediatric first aid to carry out first aid treatment and / or treatment for minor cuts / wounds as and necessary

Signature of Parent	Date

Consent for emergency treatment

If emergency treatment is required, parents will be contacted and asked to collect their child from the nursery. If the parents cannot be reached immediately, the nursery will take your child to the nearest medical centre or hospital for emergency treatment. In the case of a serious emergency, an ambulance will be called immediately. Efforts to contact the parents will continue. Parents are responsible for all medical expenses, including transport expenses to the medical facility.

Signature of Parent	Date