



MEDICAL FORM

1 Child's Information	
First Name:	Birth Date:
Family Name:	

2 Medical History Does your child suffer from any of the following?	
Allergies or food restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any:
Respiratory difficulties, physical disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any:
Vision/ hearing impairments or learning difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any:
Other health concerns that require special monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any:
Has your child been hospitalized or received treatment recently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any:
Does your child have any known learning Disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any:
Does your child take any regular medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any:

3 Family Emergency Contact Information	
Name:	Mobile no.:

4 Family Emergency Contact Information	
Doctor Name:	
Office Telephone no.:	
Sponsor's Health Ins Co (Name):	Sponsor's Health Card/Ins No.:

5 Vaccination Information					
Vaccine		Date	Vaccine		Date
BCG	<input type="checkbox"/> Yes <input type="checkbox"/> No		Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No		Varicella	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DTap	<input type="checkbox"/> Yes <input type="checkbox"/> No		MMR	<input type="checkbox"/> Yes <input type="checkbox"/> No	



KIDS WORLD
NURSERIES

MEDICAL FORM

Hib	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child had any of the following illnesses? If yes, please insert date.					
Illness		Date	Illness		Date
German Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No		Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Fainting Injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No		Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Poliomyelitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Colds/Sinusitis/H1N1	<input type="checkbox"/> Yes <input type="checkbox"/> No		Operation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

6 Non-prescription Medicine Administration

I hereby authorize Kids World Nursery to administer the following medication/products according to manufacturer/physician's written instructions should it be required. Other medication may be administered as required, subject to my sign off on the Medicine Administering Form available in the office. I will not hold Kids World Nursery liable for any unforeseen incident, allergic reactions, or other symptoms when the medication/products are used in accordance with these terms.

Paracetamol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment
First Aid Ointment/ Sudocreme	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment
Insect Bite Cream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment
Signature of Parent/Guardian:		Date:

7 Non-prescription Medicine Administration

Children have a low resistance to infection. If your child is ill, he/she should not attend nursery until fully clear of illness/infection. If called to collect your child, I will endeavor to be at the nursery within one hour. In the nature of an event, I agree to the nursery nurse providing emergency care including calling an ambulance and/or physician for medical attention. I agree to pay for any/all costs incurred and take full responsibility for treatment required and will not hold the nursery liable in the event that we are unable to reach the parent and confirm the course of action.

Signature of Parent/Guardian Date

Name of Parent (Please Print)

7 Parent Signoff

I hereby confirm that all the above medical information is accurate and correct to the best of my knowledge. I endeavor to provide Kids World Nursery with any changes to this information as and when I become aware of them and have attached my child most updated immunization to this completed document.

Signature of Parent/Guardian Date

Name of Parent (Please Print)

FOR INTERNAL USE:

Date Received: Signature: