MEDICAL FORM

Child's Information

Full Name: ____

Gender: ______________________ Date of Birth: ______________________

Emergency Contact Information:

In case of an emergency, if parents cannot be reached, please provide 2 emergency contacts:

Name: ______________________ Relationship: ______________________

Contact Numbers: ____

Name: ______________________ Relationship ______________________

Contact Numbers: ____

Family Physician Information:

Doctor's Name: ______________________ Contact No: ______________________

Medical Practice/Clinic: ______________________ Tel. No: ______________________

Practice/Clinic's Address: ____

Insurance Information:

Is your child covered by health insurance? ________ If yes, please give the following details:

Health Insurance Co: ______________________ Health Insurance Card No: ______________________

(Please also attach a photocopy of your child's health insurance card)

Does your child have a UAE Health Card? ____

If yes, please attach a photocopy of your child's UAE Health Card.

Medical History

Does your child have any of the following medical issues?

	Yes	No	Details (if any)
Allergies			
Other Food Intolerances/Dietary Restriction			
Asthma / Other Respiratory Difficulties			
High Fever / Sinusitis			

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Eczema / Skin Disorders			
Epilepsy			
Diabetes			
Heart Problems			
Vision / Medical Disability			
Physical / Mental Disability			
Special Learning Needs			
Any Other Health Issues			

Does your child take any regular medication? ________________________________

If yes, please give details: ________________________________

Has your child ever been hospitalized or undergone surgery? ________________________________

If yes, please give details: ________________________________

Has your child received any recent medical treatment? ________________________________

If yes, please give details: ________________________________

Has your child ever suffered from any of the following?

Illness	Yes	No	Date	Illness	Yes	No	Date
Chicken Pox				Pneumonia			
Diphtheria				Tonsillitis			
Dysentery				Rheumatic Fever			
Fainting Illness				Rubella			
Foot & Mouth				Scarlet Fever			
Hepatitis				Strep Throat			
Measles				Swine Flu (H1N1)			
Mumps				Tuberculosis			

The Cardinal Valley Nursery
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Polio				Whooping Cough			
Other:				Other:			

<u>Vaccination Information:</u>
Has your child received the following vaccinations? Please tick (to indicate yes) or cross (to indicate no) the box, as appropriate.

Tuberculosis (BCG)	Birth				
Hepatitis B	Birth	2 month ☐	6 month ☐		
DTAP, DT	2 month ☐	4 month ☐	6 month ☐	18 month ☐	3-5 Yrs. ☐
HIB	2 month ☐	4 month ☐	6 month ☐	18 month ☐	
Polio (IPV)	2 month ☐	4 month ☐	6 month ☐	18 month ☐	3-5 Yrs. ☐
Pneumococcal (PCV)	2 month ☐	4 month ☐	6 month ☐	18 month ☐	
MMR			12 month ☐		3-5 Yrs. ☐
Varicella			12 month ☐		3-5 Yrs. ☐
Hepatitis A			12-18mth ☐	18-24mth ☐	
Meningitis					
Flu					

I hereby confirm that all the above medical information is correct and accurate, to the best of my knowledge. I agree to provide The Cardinal Valley Nursery with any changes to this information as and when I become aware of them. I have attached my child's most up-to-date immunization records, as requested.

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Parent/Guardian Signature over printed Name:

Date: ______________________________

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Authorization for General Medical Treatment

I hereby authorize the Nursery Nurse of The Cardinal Valley Nursery to examine my child and provide medical care to my child in case of minor accident, injury or illness, including but not limited to, bruises, bumps, cuts, grazes, stings, bites, fever, pain, etc. I further authorize the Nursery Nurse to administer the following medication/products be required:

Medication/Product	Yes	No	Comments
Calpol (Paracetamol)			
Antiseptic			
Insect Bite Cream			
Sunscreen			
Ventolin Inhaler			Provided by Parent only
Epi - Pen			Provided by Parent only

I agree not to hold The Cardinal Valley Nursery responsible for any allergic reaction or other adverse symptoms that may result, when such medication/products are used on the above terms.

Signature of Parent/Guardian: ______________________________

Name of Parent/Guardian: ______________________________

Date: ____________________

Authorization for Emergency Medical Treatment:

In case of accident, illness or emergency, I authorize The Cardinal Valley Nursery Nurse to provide emergency medical care to my child, including calling an ambulance and/or physician for emergency medical treatment. In the event that I, the other parent and the Emergency Contacts listed in this form cannot be reached to confirm a course of action, I take full responsibility for the emergency medical treatment required and I agree to pay for any and all costs incurred in such case. I further agree not to hold the Nursery liable for any consequences arising from such emergency medical treatment.

Signature of Parent/Guardian: ______________________________

Name of Parent/Guardian: ______________________________

Date: ____________________

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