Nursery Medical Form

T: +971 (4) 352-3600
F: +971 (4) 352-2326
E: info@steupnursery.com
W: www.stepupnursery.com

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 ☐ Yes ☐ No	Provide details if any:
Respiratory difficulties, physical disability ☐ Yes ☐ No	Provide details if any:
Vision/ hearing impairments or learning difficulties ☐ Yes ☐ No	Provide details if any:
Other health concerns that require special monitoring ☐ Yes ☐ No	Provide details if any:
Has your child been hospitalized or received treatment recently? ☐ Yes ☐ No	Provide details if any:
Does your child have any known learning Disabilities ☐ Yes ☐ No	Provide details if any:
Does your child take any regular medication ☐ Yes ☐ 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	☐ Yes ☐ No		Polio	☐ Yes ☐ No	
Hepatitis B	☐ Yes ☐ No		Varicella	☐ Yes ☐ No	
DTap	☐ Yes ☐ No		MMR	☐ Yes ☐ No	

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

6 Non-prescription Medicine Administration

I hereby authorize StepUp 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 StepUP Nursery liable for any unforeseen incident, allergic reactions, or other symptoms when the medication/products are used in accordance with these terms.

Paracetamol	☐ Yes ☐ No	Comment
First Aid Ointment/ Sudocreme	☐ Yes ☐ No	Comment
Insect Bite Cream	☐ Yes ☐ 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 StepUp 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:	