



MEDICAL FORM

1 Student Information

First Name:	Birth Date:
Family Name:	

2 Medical History Does your child suffer form 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 concern that requires special monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any
Has your child been hospitalized received treatment recently <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any

3 Family Physician

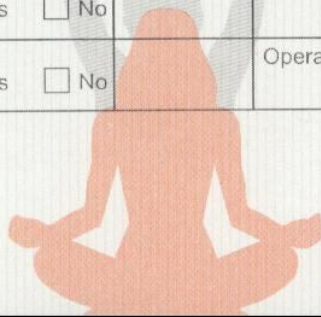
Doctor Name:	Emergency No:
Telephone No:	Emergency No:
Health Ins Co:	Health Card/Ins No:

4 Vaccination Information

Has your child received the following vaccination? If yes, please insert date.

Vaccine		Date	Vaccine		Date
Diphtheria, Tetanus, Pertussis (Triple Antigen 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No		BCG Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diphtheria, Tetanus, Pertussis (Triple Antigen 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Pre Nursery Booster	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diphtheria, Tetanus, Pertussis (Triple Antigen 3)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Frequent Cold/ Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No		Operation	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Foundation for the Future . . .



Foundation for the future . . .



Has your child had any of the following illness? 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	Other (specify)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Colds/Sinusitis/H1N1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No

5 Non-prescription Medicine Administration

I hereby authorise Gurusthanam Playschool, 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 Gurusthanam Playschool liable for any allergic reactions or other symptoms when the medication/products are used in accordance with these terms.

Medicine	Symptoms	Remarks	Instructions
Calpol Syrup	<ul style="list-style-type: none"> ● Fever ● Teething pain ● Headache ● Anti-allergy 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fenistil Gel	<ul style="list-style-type: none"> ● Insect bites ● Itchy skin 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Betadine Ointment / Betadine Solution	<ul style="list-style-type: none"> ● Antiseptic ● Superficial wound ● Infected dermatoses ● Clean infected wound 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fucidine Ointment	<ul style="list-style-type: none"> ● Minor and major wounds 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arnica Gel	<ul style="list-style-type: none"> ● Bumps, bruise, strains, etc 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments			



Foundation for the Future . . .



6 Non-prescription Medicine Administration

Children have a low resistance to infection. If your child is ill, he/she should not attend Gurusthanam Playschool until fully clear of illness/infection. If called to collect your child, I will endeavour to be at the Gurusthanam Playschool within one hour. In the nature of an event, I agree to the Gurusthanam Playschool 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

7 Parent Signoff

I hereby confirm that all the above medical information is accurate and correct to the best of my knowledge. I endeavour to provide Gurusthanam Playschool 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

IMPORTANT NOTICE

The child needs to stay home or leave the nursery if the following symptoms are found:

- Fever and sore throat, rash, vomiting, earache, irritability or confusion
- Diarrhea- runny, watery or bloody stools.
- Vomiting- 2 or more times.
- Body rash with fever.
- Head lice found in their hair.
- Sore throat with fever and swollen glands.
- Severe coughing- Child gets blue or red in the face or makes high pitched whooping sound after coughing.
- Eye Discharge- Thick mucus or pus draining from the eye.
- Yellowish skin or eyes.
- Child is irritable, continuously crying, or requires more attention that can be provided without affecting the health and safety of the other children.

FOR INTERNAL USE:

Date Received	Signature	Follow up
---------------	-----------	-----------