

MEDICAL FORM

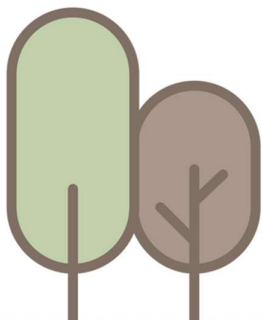
Child Details

First Name	<input type="text"/>	Date of Birth	<input type="text"/>
Surname	<input type="text"/>		
Family Doctor Name In the UAE	<input type="text"/>		
Family Doctor Contact Details	<input type="text"/>		
Clinic / Hospital Name And Contact Details	<input type="text"/>		

Medical Information / History

Details of your child's medical condition / illnesses

Measles	<input type="checkbox"/>	Infectious Hepatitis	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	Poliomyelitis	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	Diabetes (Type 1 or 2)	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Hearing Difficulties	<input type="checkbox"/>	Vision Difficulties	<input type="checkbox"/>
Skin Disorder	<input type="checkbox"/>	Thalassemia	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	Hemophilia (Bleeding Tendency)	<input type="checkbox"/>	Typhoid Fever	<input type="checkbox"/>

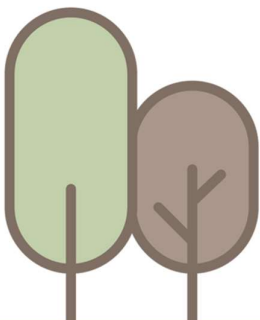


Additional Medical Information

Child Details

Any allergic reactions	<div style="border: 1px solid black; height: 30px;"></div>
Any food restrictions	<div style="border: 1px solid black; height: 30px;"></div>
Regular medication that your child requires (if any)	<div style="border: 1px solid black; height: 45px;"></div>
Previous surgery	<div style="border: 1px solid black; height: 30px;"></div>
Traumas	<div style="border: 1px solid black; height: 30px;"></div>
Blood Type	<div style="border: 1px solid black; height: 30px;"></div>

If your child requires any additional developmental needs, please clarify here:



Emergency Consent

I understand that in case of any health concern I will be contacted immediately to collect my child. In case of any emergency treatment that is required where my child cannot be collected by me or the authorised person, I hereby authorise. The House of Learning to take my child to the nearest hospital / medical centre / clinic for emergency treatment.

In case of emergency that requires immediate first aid treatment and hospitalization, I authorise The House of Learning to call paramedics / ambulance. I understand that these measures are required for the health benefits of my child and will take full responsibility for all medical expenses associated with emergency treatment.

Signature: _____ Date: _____

Declaration

The above is a true and accurate statement of my circumstances and I agree to inform the nursery of any changes immediately.

Signature: _____ Date: _____

Data and Privacy Protection:

The information given on this form will be held on computer systems and will be used only for the purpose of my child's health monitoring and medical emergency action.

Authorisation for Medication

If The House Of Learning can not reach _____, I give consent for them to administrate medication to my child if the first aid trained staff may help with temperature or pain. I authorise The House Of Learning to use Panadol Baby (Paracetamol Suspension) as treatment.

