Littlewoods
EARLY LEARNING CENTER

MEDICAL FORM

Child's Information

Full Name:

Gender: M F

Date of Birth: / /

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

Name: Relationship:

Contact Numbers:

Name: Relationship:

Contact Numbers:

Family physician information

Doctor's Name:

Medical Practices/Clinic:

Contact Number:

Medical Practices/Clinic Address: _____

Insurance Information

Is Your Child Covered by Health Insurance? Y N 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?: Y N 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 Restrictions			
Asthma/Other Respiratory Diffculties			
Hay Fever/Sinusitis			
Eczema/Skin Disorders			
Epilepsy			
Diabetes			
Heart Problems			
Vision/Hearing Impairment			
Physical/Mental Disability			
Special Learning Needs			
Any other Health Issues			

Does your child takes any regular medication? Y | N

If yes, please give details_____

_____

Has your child ever been hospitalised or undergone surgery? Y | N

If yes, please give details_____

_____

Has your child received any recent medical treatment? Y | N

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			
Polio				Whooping Cough			
Other				Other			

Vaccination Information

Has your child received the following vaccinations? Please tick (to indicate 'yes') or cross (to indicate 'no') in the box, as appropriate.

Tuberculosis (BCG)	Birth				
Hepatitis B	Birth ☐	2mth ☐	6mth ☐	☐	☐
DTaP.DT	2mth ☐	4 mth ☐	6 mth ☐	18mth ☐	3 – 5yrs
HiB	2mth ☐	4 mth ☐	6 mth ☐	18 mth ☐	☐
Polio (IPV)	2mth	4 mth	6 mth	18 mth	3 – 5yrs
Pneumococcal (PCV)	2mth ☐	4 mth ☐	6 mth ☐	18 mth ☐	
MMR			12mth ☐		3 – 5yrs ☐
Varicella			12 mth ☐		3 – 5yrs ☐
Hepatitis A			12 – 18 mth ☐	18 – 24mth ☐	
Meningococcal					
Flu					

I hereby confirm that all the above medical information is correct and accurate, to the best of my knowledge.

I agree to provide Littlewoods Early Learning Center with any changes to this information as and when I become aware of them.
I have attached my child's most up-to-date immunisation records, as requested.

_____ _____

Signature of Parent/Guardian **Name of Parent/Guardian**

Date:_____

Authorisation for General Medical Treatment

I hereby authorise the Littlewoods Early Learning Center Nurse 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 Littlewoods Early Learning Center to administer the following medication/products in accordance with the manufacturer's written instructions, should such medication/products be required:

Medication/Product	Yes	No	Comments
Paracetamol			
First Aid Ointment			
Antiseptic			
Insect Bite Cream			

I agree not to hold Littlewoods Early Learning Center 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:_____

Authorisation for Emergency Medical Treatment

In case of accident, illness or emergency, I authorise the Littlewoods Early Learning Center 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 or 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 Littlewoods Early Learning Center liable for any consequences arising from such emergency medical treatment.

Signature of Parent/Guardian **Name of Parent/Guardian**

Date:_____