LOLLIPOP
NURSERY AND DAY CARE
Gift your child a better tomorrow, today.

MEDICAL FORM

Child's Photo

General Information

CHILD INFORMATION:

First Name: _____ Last Name: _____

Age: _____ Gender: ☐ Male ☐ Female

DOCTOR'S DETAILS:

Family Doctor's Name: _____ Tel No.: ☐☐☐☐☐☐☐☐☐☐☐

Mobile No.: _____ Clinic Name: _____

Clinic Address: _____

Health Card No.: _____ Health Insurance Company: _____

Vaccination Details

HAS YOUR CHILD RECEIVED THE FOLLOWING VACCINATIONS?

BCG	YES ☐	NO ☐	Hepatitis B	YES ☐	NO ☐
DPT/Hib/Polio (Two months)	YES ☐	NO ☐	Meningococcal (for Meningitis)	YES ☐	NO ☐
DPT/Hib/Polio (4 months)	YES ☐	NO ☐	DPT/Hib/Polio (6 months)	YES ☐	NO ☐
DPT/Hib/Polio (18 months)	YES ☐	NO ☐	MMR	YES ☐	NO ☐
Chickenpox	YES ☐	NO ☐	Varicella (13 months)	YES ☐	NO ☐
Hepatitis A	YES ☐	NO ☐	ROTA Vaccine	YES ☐	NO ☐
Pneumococcal	YES ☐	NO ☐			

Diseases

HAS YOUR CHILD HAD THE FOLLOWING DISEASES?

Frequent Colds/Sinusitis/H1-N1	YES ☐	NO ☐	Rheumatic Fever	YES ☐	NO ☐
Fainting	YES ☐	NO ☐	Stomach/Intestinal Infections	YES ☐	NO ☐
Asthma	YES ☐	NO ☐	Chickenpox	YES ☐	NO ☐
Epilepsy	YES ☐	NO ☐	Whooping Cough	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Heart Trouble	YES ☐	NO ☐
Rubella	YES ☐	NO ☐	Scarlet Fever	YES ☐	NO ☐
Measles	YES ☐	NO ☐	Operations (Specify)	YES ☐	NO ☐
Mumps	YES ☐	NO ☐	Tuberculosis	YES ☐	NO ☐

Diseases

Serious Injuries (Specify)	YES ☐	NO ☐	Bone/Joint Fractures/Injuries	YES ☐	NO ☐
Pneumonia	YES ☐	NO ☐	Poliomyelitis	YES ☐	NO ☐
Skin infections/Rashes/Disorders	YES ☐	NO ☐			

Others (Please specify) _____

Current Health Information

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? (PLEASE TICK)

☐ Learning Difficulties ☐ Vision Impairments ☐ Hearing Disabilities ☐ Physical Disabilities

☐ Respiratory Problems ☐ Allergies ☐ Food Allergies

Other Health Problems: _____

_____

Does your child have any special condition that requires extra monitoring? ☐ YES ☐ NO

Details: _____

_____

Does your child take any regular medication or inhalers that require our monitoring and assistance? ☐ YES ☐ NO

Details: _____

_____

Please note:- The Nursery will only administer and assist with medication that has a formal Doctor's prescription. Please present the Doctor's prescription form to the Nursery Nurse.

Health Undertaking

MEDICAL AND MEDICINE ADMINISTRATION

I agree that the school may administer the following should it be required. The school will endeavor to telephone me should this be required. Any other medication may be administered as required in emergency or, subject to the signing off by the Parent signing the Medicine Administer form.

Calpol	YES ☐	NO ☐	Pain relief cream	YES ☐	NO ☐
Antiseptic	YES ☐	NO ☐	Insect Bite Cream	YES ☐	NO ☐
Sunscreen	YES ☐	NO ☐	Sticking Plastic	YES ☐	NO ☐

Parent's Name: _____ Signature: _____ Date: _____

Children who are not well should not attend the Nursery and remain away until fully clear of illness / infection. In order to prevent the illness spreading to children in the Lollipop Nursery, we advise the Parents to refrain from bringing your child to the Nursery for a minimum of 48hrs. Your child must be symptom free before you bring your child back to the Nursery.

To reduce the risk of cross infection, I agree to abide by the Nursery Health Policy which outlines the requisite time away from the nursery, subject to change. In the event of an emergency, I agree to the School Nurse and / or any member of staff providing emergency care including, if required, calling an ambulance or calling in medical attention.

If called in for a medical reason, I will endeavour to be at the nursery to collect my child within a maximum of 1 hour and in no event after closing time. I agree that I will be responsible for any and all costs incurred and take full responsibility for treatment required and hold the nursery and its staff harmless in the event that we are unable to reach the parent and / or emergency contact to confirm the course of action to take. I agree to the Nursery Medical Terms and Conditions and agree to be bound by them.

Parent's Name: _____ Signature: _____ Date: _____

I hereby confirm that all the above medical information is accurate and correct to the best of my knowledge. I endeavour to provide Lollipop Nursery with any changes to this information as and when I become aware of them and have attached my child's updated immunization form to this completed questionnaire.

Parent's Name: _____ Signature: _____ Date: _____