Medical Form

Child Paediatrician Details			
Child's Full Name:		Nationality:	
Child's D.O.B:		Gender: Male/Female:	
Name of Doctor:		Clinic/Hospital:	

Child's Medical History					
Does your child have any of the following conditions/ illnesses?					
Type of illness	**Y**	**N**	**Type of illness**	**Y**	**N**
Measles	☐	☐	Diabetes Type 1 or 2	☐	☐
German Measles	☐	☐	Epilepsy	☐	☐
Chicken Pox	☐	☐	Heart trouble	☐	☐
Mumps	☐	☐	Rheumatic Fever	☐	☐
Whooping Cough	☐	☐	Asthma	☐	☐
Scarlet Fever	☐	☐	Convulsions	☐	☐
Hand, Foot & Mouth Disease	☐	☐	Kidney Disease	☐	☐
Infectious Hepatitis	☐	☐	Tuberculosis	☐	☐
Poliomyelitis	☐	☐	Hearing Difficulty	☐	☐
Pneunomia	☐	☐	Vision Difficulty	☐	☐
Malaria	☐	☐	Speech Difficulty	☐	☐
Meningitis	☐	☐	Bronchitis	☐	☐
Chronic illness	☐	☐	Skin Disorder/ Eczema	☐	☐

Additional Information

If you have selected “Y” for any of the conditions/illnesses, please provide more information:

Allergies

Does your child suffer from any allergies? Yes/No If Yes, please provide more information:

Medication

Does your child require any medications? Yes/No If Yes, please provide more information:

Medical Consent

Administration of “over the counter’ medicine

I have given the authorization to the nurse/authorized person of Bumble Bee Nursery to administer the above mentioned medication and dosage to my child. Bumble Bee Nursery will not be held liable for any side effects incurred to my child by taking this medication.

Parents/Care’s Full Name: _____ Date: _____

Signature: _____ Email: _____