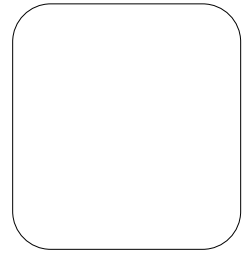




Medical Form



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	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type 1 or 2	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Hand, Foot & Mouth Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Vision Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic illness	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder/ Eczema	<input type="checkbox"/>	<input type="checkbox"/>

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: _____