IDEA early learning center
INSPIRE. DEVELOP. EDUCATE. ACHIEVE.

Medical Questionnaire

Child Information

First Name _____ Family Name _____

Date of Birth (DD/MM/YY) _____ Age _____ Gender ☐ Male ☐ Female

Has Your Child Received The Following Vaccinations?

*BCG	☐ YES	☐ NO	MMR (13 months)	☐ YES	☐ NO
*DPT/Polio /Hib (2 months)	☐ YES	☐ NO	Varicella (13 months)	☐ YES	☐ NO
*Meningococcus (3 months)	☐ YES	☐ NO	Hepatitis A	☐ YES	☐ NO
*Rotavirus (2/3 months)	☐ YES	☐ NO	*DPT/Polio (36 months)	☐ YES	☐ NO
*DPT/Polio Hib (4 months)	☐ YES	☐ NO	*MMR (36 months)	☐ YES	☐ NO
*Meningococcus (12 months)	☐ YES	☐ NO	Varicella (4-6 years)	☐ YES	☐ NO
*Hepatitis B (UAE)	☐ YES	☐ NO	PCV (Pneumococcal Conjudate Vaccine)	☐ YES	☐ NO

*Indicate British Standards Immunisations

Has Your Child Had Any Of The Following Illnesses oa Suffer From Any Of These Conditions?

Chicken Pox	☐ YES	☐ NO	Frequent Colds/ Sinusitis/H1N1	☐ YES	☐ NO
Whooping Cough (Pertussis)	☐ YES	☐ NO	Fainting	☐ YES	☐ NO
German Measles (Rubella)	☐ YES	☐ NO	Asthma	☐ YES	☐ NO
7 day Measles (Rubeola)	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO
Mumps	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO	Heart Trouble	☐ YES	☐ NO
Scarlet Fever	☐ YES	☐ NO	Operations (Specify)	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO	Serious Injuries (Specify)	☐ YES	☐ NO
Pneumonia	☐ YES	☐ NO	Tonsillitis	☐ YES	☐ NO
Poliomyelitis	☐ YES	☐ NO	Other (Specify)	☐ YES	☐ NO

Please note if you / your child has come into contact with any infectious disease or travelled to an area of concern in past 3 months:

_____

Does Your Child Have Any Vision / Hearing Impairments or Learning Difficulties?

☐ YES ☐ NO If yes, please give detail and attach any relevant therapy reports: _____

Does Your Child Have Any Allergies or Food Restrictions?

☐ YES ☐ NO If nuts, please give details: _____

Does Your Child Take Medicine On Regular Basis or Have Any Respiratory Difficulties, Physical Disability or Other Reason To Have Restricted Physical Activity?

☐ YES ☐ NO give detail, if yes: _____

Does Your Child Have Any Other Health Issue Or Require Any Special Monitoring?

☐ YES ☐ NO give detail, if yes: _____

Medicines Policy / Medical & Medicine Administration

Children who are not well should not attend nursery. The nursery program is active and involved so if they need rest or fever reducers, children must be kept at home. I agree that the school will administer Calpol / pain relief / fever reduction medication should it be required. A fever over 39 degrees is such a case. The school will endeavour to telephone me should this be required. Any other medication will be administered as required in an emergency or in caregivers discretion subject to the singing off by the Parent of the Medicine Administering Form available in the office which must be completed by parent prior to any medication being left on premises.

I have read and understood the full medicines policy/Medical and Medicine and administration.

Date _____ **Signature of Parent/Guardian** _____

Nursery Health Policy / Emergency Treatment / Safeguarding Policy

Children who are not well should not attend Nursery and remain away until fully clear of illness / infection. To reduce the risk of cross infection, I agree to abide by the Nursery Healthy 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 be at the nursery to collect my child within a maximum of 1 hour from the time of call 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 Terms and Conditions, the Safeguarding Policy and Process and agree to be bound by them by registering and signing herein.

I have read and understood the full Nursery Health policy, Emergency Treatment and Safeguarding policy.

Date _____ **Signature of Parent/Guardian** _____

Child's Family Doctor Information

Doctor's name _____ Emergency No _____

Telephone No _____ Mobile _____ Preferred Hospital _____

Health Ins. Co _____ Health Card No _____

Parental Update of Information

I hereby confirm that all the above medication information is accurate and correct to the best of my knowledge. I endeavour to provide IDEA Nursery with any changes to this information in writing as and when I become aware of them, keeping the nursery file up to date at all times. I have attached my child's updated immunization form to this completed questionnaire.

Date _____ **Signature of Parent/Guardian** _____

For Internal Only

Date received _____ **Signature** _____ **Follow up** _____