CONFIDENTIAL

Medical Record

TO BE COMPLETED ON BEHALF OF ALL CHILDREN

PLEASE ANSWER ALL OF THE QUESTIONS
AND SIGN ALL DECLARATIONS

CHILD'S SURNAME *(block capitals)*:……...…

FIRST NAMES *(block capitals)*:……

START DATE: ……..…..

DATE OF BIRTH:…… **GENDER:** ……

RELIGION: …… **ETHNIC ORIGIN:** ……

NATIONALITY: ……...

NHS NUMBER (if known – on NHS card): ……...…

To protect children and staff from possible infection, if your child has had temperature or has been suffering with vomiting or diarrhoea; please wait 48 hours before sending him/her back to Nursery.

PARENTS' DETAILS:	
Father:	**Mother:**
Home Address:	**Home Address** *(if different):*
Home Telephone:	**Home Telephone:**
Work Telephone:	**Work Telephone:**
Mobile:	**Mobile:**
E-mail Address:	**E-mail Address:**
EMERGENCY CONTACT:	
Name:	**Telephone No:**
Address:	**Mobile No:**

GENERAL PRACTITIONER DETAILS:	
Name:	**Telephone No:**
Address:	

MEDICAL INFORMATION	
Has your child had any of the following infections? Please state age or date affected.	Has your child been inoculated against the following? Please give age at last inoculation in each case.
Mumps	Diphtheria
Chicken Pox	Whooping Cough
Whooping Cough	Tetanus
Measles	Poliomyelitis
Rubella	MMR
Scarlet Fever	Measles
Diphtheria	Tuberculosis (BCG)
Rheumatic Fever	Rubella
Tuberculosis	Hepatitis A
Meningitis	Hepatitis B
Other	Other

Dietary Requirements:
Does your child have any specific dietary requirements or food allergies:

……

……

……

Allergies:
If your child has a history of allergies complaints, e.g. hay fever, asthma, eczema etc. please give details:

……

……

……

Is your child allergic to any substances or sensitive to any drugs?

……

……

……

Surgical Operations:
Please give details of any surgical operations:

……

……

Is there any on-going treatment we should be aware of?

……

……

Medical Conditions:
If your child has suffered from any other serious medical conditions, please give details and dates, including hospitalisations:

……

……

Eye Sight:
If your child has an eyesight problem, please give details:

……

……

Deafness, Ear Infections, Aural Discharge, Nose or Throat Conditions:
If your child suffers from deafness, ear infections or aural discharge, nose and throat conditions, please give details:

……

……

Please give details on a separate sheet (to be enclosed) if:

- Your child has ever had any fits or has had epilepsy.
- You have lived overseas and your child has had any tropical disease.
- Your child exhibits identifiable stress reactions.
- Other information that you consider appropriate

Please note all medications should be handed directly to the Manager or Deputy Manager who will, "with your consent", administer medication. This should be clearly marked with the child's name, and dosage details.

MEDICAL CONSENT FORM

Name of child: ……

I, ……being parent/guardian of the above named child give permission for the Nursery Manager/Holiday Club Staff to give necessary emergency medical or surgical treatment recommended by competent medical authorities, where it would be contrary to my son/daughter's interest (in the doctor's medical opinion) for any delay to be incurred, by seeking my personal consent, should I be unobtainable.

Name: …… Signature:……

Relationship to child: ……... Date: ……..……..…

Name: …… Signature:……....

Relationship to child: …… Date: …….

Consent to administer non-prescription medication such as mild analgesia and first-aid treatment as necessary:

Signature: …….. (print signature)……..….

Date: …….

Consent to apply sun protection cream as and when required:

Signature: …….. (print signature)……..….

Date: …….

IT IS VERY IMPORTANT THAT WE ARE KEPT UP-TO-DATE WITH ANY CHANGES OF ADDRESS AND TELEPHONE NUMBERS (INCLUDING DOCTOR'S DETAILS)