medical record

Child's name: ____________________

Date of Birth: ____________________

PASSPORT SIZE PHOTO

Emergency Contact

Name: ____________________ Telephone: ____________________

Family Doctor: ____________________ Telephone: ____________________

Health Related Issues

Does your child have, or has your child suffered from the following:

YES	NO		YES	NO		YES	NO	
☐	☐	Allergies	☐	☐	Hernia	☐	☐	Diabetes
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Elilepsy
☐	☐	Bone/joint injury	☐	☐	Heart Disease	☐	☐	Skin Disorder
☐	☐	Chronic illness	☐	☐	Loss of Hearing	☐	☐	Thalassemia
☐	☐	Concussion	☐	☐	Rheumatic Fever			

If you have answered yes to any of the above, please see the Director or the School Nurse.

Please tick the correct box and give the date, if your child has suffered from any of the following illnesses:

YES	NO		YES	NO	
☐	☐	Chicken Pox ____________	☐	☐	Infective Hepatitis ____________
☐	☐	Diptheria ____________	☐	☐	Measles ____________
☐	☐	Dysentry ____________	☐	☐	Rubella ____________
☐	☐	Scarlet Fever ____________	☐	☐	Tuberculosis ____________
☐	☐	Whooping Cough ____________			

Please write here any important information relating to your child's health that you feel we might need to know.

____

In the event of The Step By Step Nursery being unable to contact me in an emergency, ☐ I consent ☐ I do not consent to the School Nurse or doctor, administering emergency and/or first aid treatment to my child, during nursery hours.

Signature: ____________________ Date: ____________________

Name in capital letters: ____________________

www.stepbystepnursery.ae