building blocks nursery

Medical **Form**

1 Student Information	
First Name:	Birth Date:
Family Name:	

2 Medical History **Does your child suffer from any of the following?**	
Allergies or food restrictions ☐Yes ☐No	Provide details if any
Respiratory difficulties, physical disability ☐Yes ☐No	Provide details if any
Vision/hearing impairments or learning difficulties ☐Yes ☐No	Provide details if any
Other health concern that requires special monitoring ☐Yes ☐No	Provide details if any
Has your child been hospitalised or received treatment recently ☐Yes ☐No	Provide details if any

3 Dietary Needs

☐Lactose Intolerance ☐Vegan ☐Vegetarian

☐For religious reasons please do not allow my child to have

☐My child has a food intolerance to

Does the child have a life threatening food allergy? ☐Yes ☐No

Food Allergies: Check appropriate box(es): ☐Ingestion ☐Contact ☐Inhalation

☐Milk ☐Wheat ☐Soy ☐Peanuts ☐Tree nuts
☐Fish ☐Shellfish ☐Whole eggs ☐Egg as an ingredient ☐Gluten

☐Others (please be specific):

4 Vaccination Information

Has your child received the following vaccination? If yes, please insert date.

Vaccine		**Date**	**Vaccine**		**Date**
Diptheria, Tetanus, Pertussis (Tripple Antigen 1)	☐Yes ☐No		BCG Tuberculosis	☐Yes ☐No	
Diptheria, Tetanus, Pertussis (Tripple Antigen 2)	☐Yes ☐No		Pre Nursery Booster	☐Yes ☐No	

Diptheria, Tetanus, Pertussis (Tripple Antigen 3)	☐Yes ☐No		Frequent Cold/ Sinusitis	☐Yes ☐No	
Measles	☐Yes ☐No		Heart Trouble	☐Yes ☐No	

Has your child had any of the following illnesses? If yes, please insert date

Illness		**Dates**	**Illness**		**Dates**
German Measles	☐Yes ☐No		Pneumonia	☐Yes ☐No	
Whooping Cough	☐Yes ☐No		Faithing Injuries	☐Yes ☐No	
Chicken Pox	☐Yes ☐No		Tonsillitis	☐Yes ☐No	
Mumps	☐Yes ☐No		Asthma	☐Yes ☐No	
Poliomyelitis	☐Yes ☐No		Epilepsy	☐Yes ☐No	
Tuberculosis	☐Yes ☐No		Diabetes	☐Yes ☐No	
Rheumatic Fever	☐Yes ☐No		Other (specify)	☐Yes ☐No	
Frequent Colds/Sinusitis/H1N1	☐Yes ☐No		Polio	☐Yes ☐No	

5 Non-prescription Medicine Administration

I hereby authorise Building Blocks, to administer the following medication/products according to manufacturer/physician's written instructions should it be required. Other medication may be administered as required, subject to my sign off on the Medicine Administering Form available in the office. I will not hold Building Blocks liable for any allergic reactions or other symptoms when the medication/products are used in accordance with these terms.

Calpol	☐Yes ☐No	Comment
First Aid Ointment	☐Yes ☐No	Comment
Insect Bite Cream	☐Yes ☐No	Comment

Signature of Parent/Guardian

6 Non-prescription Medicine Administration

Children have a low resistance to infection. If your child is ill, he/she should not attend nursery until fully clear of illness/infection. If called to collect your child, I will endeavour to be at the nursery within one hour. In the nature of an event, I agree to the nursery nurse providing emergency care including, calling an ambulance and/or physician for medical attention. I agree to pay for any.all cost incurred and take full responsibility for treatment required and ill not hold the nursery liable in the event that we are unable to reach the parent and confirm the course of action.

Signature of Parent/Guiardian **Date**

Name of Parent

7 Parent Signoff

I hereby confirm that all the above medical information is accurate and correct to the best of my knowledge. I endeavour to provide Building Blocks with any changes to this information as and when I become aware of them and have attached my child most updated immunization to this completed ducument.

Signature of Parent/Guardian **Date**

Name of Parent

FOR INTERNAL USE:

Date Received	Signature	Follow up