



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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any
Respiratory difficulties, physical disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any
Vision/hearing impairments or learning difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any
Other health concern that requires special monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any
Has your child been hospitalised or received treatment recently <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details if any

3 Family Physician	
Doctor Name:	Emergency No:
Telephone No:	Mobile No:
Health Ins Co:	Health Card/Ins No:

4 Vaccination Information					
Has your child received the following vaccination? If yes, please insert date.					
Vaccine		Date	Vaccine		Date
Diphtheria, Tetanus, Pertussis(Triple Antigen 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No		BCG Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diphtheria, Tetanus, Pertussis(Triple Antigen 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Pre Nursery Booster	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diphtheria, Tetanus, Pertussis(Triple Antigen 3)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Frequent Cold/ Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No		Operation	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Has your child had any of the following illnesses? If yes, please insert date					
Illness		Date	Illness		Date
German Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No		Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Fainting Injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No		Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Poliomyelitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Colds/Sinusitis/H1N1	<input type="checkbox"/> Yes <input type="checkbox"/> No		Polio	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment
First Aid Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment
Insect Bite Cream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment
<b>Signature of Parent/Guardian</b>		<b>Date</b>

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 costs incurred and take full responsibility for treatment required and will not hold the nursery liable in the event that we are unable to reach the parent and confirm the course of action.	
<b>Signature of Parent/Guardian</b>	<b>Date</b>
<b>Name of Parent</b>	

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 document.	
<b>Signature of Parent/Guardian</b>	<b>Date</b>
<b>Name of Parent</b>	

FOR INTERNAL USE:		
Date Received	Signature	Follow up