

### MEDICAL FORM

Attach Photo



Additional Documents required:

(Documents and photos can be provided to Reception or emailed to: [nursery@creakids.ae](mailto:nursery@creakids.ae))

Copy of your Child's up to date Vaccination Record in English

1 Passport sized photo of child

#### CHILD INFORMATION

Child First Name:			Middle:			Last:		
Languages Spoken at Home				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth date: DD / MM / YY		
Home address:								
Home phone : (    )			P.O. Box:			Emirate:		

#### PARENT INFORMATION

Mother First Name:			Middle:			Last:		
Mother Mobile Phone: (    )			Mother Work Phone: (    )			Mother Other Phone: (    )		
Mother Email:								
Father First Name:			Middle:			Last:		
Father Mobile Phone: (    )			Father Work Phone: (    )			Father Other Phone: (    )		
Father Email:								

#### PHYSICIAN INFORMATION

Doctor / Physician Name:			Clinic / Hospital:					
Office Phone: (    )			Mobile Number: (    )					
Private Health Insurance Company			Private Health Insurance Number					

### MEDICAL INFORMATION

Has your child had any of the following illnesses or suffer from any of these conditions?

Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent colds/ Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
German Measles (Rubella)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poliomyelitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:		

Does your child have known allergies?

Does your child have any special dietary requirements?

Does your child have any other medical conditions?

### PARENTAL CONSENT

#### Consent for the administration of medication:

In the event that my child develops a fever, pain or allergy CreakKids Nursery staff may need to administer medication.

Medication	For treatment of:	Please Tick on the space	Medication	For treatment of:	Please Tick on the space
Paracetamol	Pain or Fever		Fenistil Gel	For insect bite	
Arnical/Arnicare Gel	Mild bruising		Fusibact/Fucidin	Antibacterial	
Antihistamine	Allergy symptoms		Others:		

Comments:

If my child is unable to use any of these medications, I will contact the Nurse to discuss the use of an alternative.

Parent Signature:

Date:

#### Consent for basic first aid and medical treatment

If needed, I give my/our permission for any member of Creakkids Nursery staff with a first aid certificate to give my child basic first aid in case of injury whilst at Creakkids Nursery and if necessary transported to the nearest medical Centre or hospital. I understand that all costs for medical treatment including ambulance or transport fees are the responsibility of the parent.

Agreed to be seen by DHA (Dubai Health Authority) licensed female/male physician for general health and wellness check-up once a month in the Nursery  YES  NO

Parent Signature:

Date:

# CreakKids

NURSERY

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REV. # 1: 28.08.2017