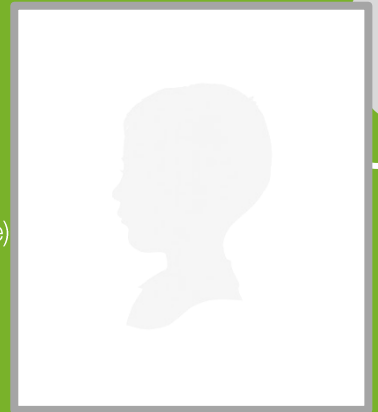


# Medical Form



Additional Documents required:

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

## 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	



**Consent for the administration of medication:**

## Medical Information

Has your child had any of the following illnesses or suffer from any of these conditions? Please check (☑) the box.

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? If yes, please specify.

Does your child have any special dietary requirements? If yes, please specify.

Does your child have any other medical conditions? If yes, please specify.

**\*\* PLEASE NOTE THAT BOTH CHILD'S PARENTS SHOULD DOWNLOAD "AL HOSN APP" AS PER THE GOVERNMENT'S REQUIREMENT. \*\***

## Parental consent

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 check (☑) on the space	Medication	For treatment of:	Please check (☑) 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:
-------------------	-------

Does your child require any learning support or have additional learning needs you are aware of:

--

I confirm all details given are correct to the best of my knowledge and understand that if support is required this would be at an additional cost.

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.

Parent Signature:	Date:
-------------------	-------