



كيدز فرست  
kids first

# Medical Form

Passport sized  
photograph  
of child

## Child's Paediatrician Details

Child's Name:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Family Name:	<input type="text"/>
Child's D.O.B:	<input type="text"/>	Sex: Male / Female	<input type="text"/>
Name of Doctor / Clinic:	<input type="text"/>	Family Clinic number:	<input type="text"/>

## Child's Health History Please indicate if your child has had any of the following conditions / illnesses;

Type of Illness	Y	N	Type of Illness	Y	N
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type 1 or 2	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Hand, Foot & Mouth Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Vision Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Chronic illness	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder / Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>

Do you need to supply the nursery with Medication for your child? If yes, please give details of the medication and the reasons for this;

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