Deerfields NURSERY

Medical Record

Child's Name: _____

Date of Birth: _____

Emergency Contact: Name _____ Relationship _____ Telephone _____

Family Doctor: Name _____ Telephone _____

Important Information

Does your child wear glasses or have an eyesight problem? ☐ Yes ☐ No

Does your child have hearing difficulties? ☐ Yes ☐ No

Does your child have any current known allergy? ☐ Yes ☐ No

If yes please state the medication used for the allergy: _____

Is your child currently on any medication? ☐ Yes ☐ No

If yes please specify the reason and type of medication: _____

And, does your child have any developmental or physical difficulties? ☐ Yes ☐ No

If yes please describe: _____

Does your child or has your child had any of the following:

Chicken Pox	☐ Yes	Date _____	☐ No	Rubella	☐ Yes	Date _____	☐ No
Diptheria	☐ Yes	Date _____	☐ No	Scarlet Fever	☐ Yes	Date _____	☐ No
Dysentery	☐ Yes	Date _____	☐ No	Tuberculosis	☐ Yes	Date _____	☐ No
Infective Hepatitis	☐ Yes	Date _____	☐ No	Whooping Cough	☐ Yes	Date _____	☐ No
Measles	☐ Yes	Date _____	☐ No	Mumps	☐ Yes	Date _____	☐ No

Does your child or has your child suffered from any of the following:

Asthma	☐ Yes	Date _____	☐ No	Hernia	☐ Yes	Date _____	☐ No
Bone/joint injury	☐ Yes	Date _____	☐ No	Heart Murmur	☐ Yes	Date _____	☐ No
Chronic illness	☐ Yes	Date _____	☐ No	Heart Disease	☐ Yes	Date _____	☐ No
Concussion	☐ Yes	Date _____	☐ No	Rheumatic Fever	☐ Yes	Date _____	☐ No
Diabetes	☐ Yes	Date _____	☐ No	Skin Disorder	☐ Yes	Date _____	☐ No
Epilepsy	☐ Yes	Date _____	☐ No	Thalassemia	☐ Yes	Date _____	☐ No

In the event of Deerfields Nursery being unable to contact me in an emergency ☐ I consent ☐ I do not consent to the nusery nurse or doctor, administering emergency and/or first aid treatment to my child, during nursery hours.

I agree, in the event of an injury or accident, that the Nursery shall have full authority to take appropriate action, including calling on government emergency services. I agree that I will be responsible for any and all cost incurred.

Is your child covered under any private medical insurance? ☐ Yes ☐ No
If yes, please attach a photocopy of the membership card.

Does your child have any developmental and/or andy medical problem? ☐ Yes ☐ No
If yes, please indicate below the nature of the condition.

_____

Parent Signature: _____ **Date:** _____

Name in capital letters: _____

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