Medical Form

Child Pediatrician Details			
Child's Full Name:		Nationality:	
Child's D.O.B:		Gender: Male/Female:	
Name of Doctor:		Clinic/Hospital:	

Child's Medical History

Does your child have any of the following conditions/ illnesses?

Type of illness	Y	N	Type of illness	Y	N
Measles	☐	☐	Diabetes Type 1 or 2	☐	☐
German Measles	☐	☐	Epilepsy	☐	☐
Chicken Pox	☐	☐	Heart Disease	☐	☐
Mumps	☐	☐	Rheumatic Fever	☐	☐
Whooping Cough	☐	☐	Asthma	☐	☐
Scarlet Fever	☐	☐	Convulsions	☐	☐
Hand, Foot & Mouth Disease	☐	☐	Kidney Disease	☐	☐
Infectious Hepatitis	☐	☐	Tuberculosis	☐	☐
Poliomyelitis	☐	☐	Hearing Difficulty	☐	☐
Pneunomia	☐	☐	Vision Difficulty	☐	☐
Malaria	☐	☐	Speech Difficulty	☐	☐
Meningitis	☐	☐	Bronchitis	☐	☐
Chronic illness	☐	☐	Skin Disorder/ Eczema	☐	☐

Additional Information

If you have selected “Y” for any of the conditions/illnesses, please provide more information:

Allergies

Does your child suffer from any allergies? Yes/No If Yes, please provide more information:

Medication

Does your child require any medications? Yes/No If Yes, please provide more information:

Medical Consent

Administration of “over the counter’ medicine

I have given the authorization to the nurse/authorized person of Honey Bee Nursery to administer the above mentioned medication and dosage to my child. Honey Bee Nursery will not be held liable for any side effects incurred to my child by taking this medication.

All the information provided in this medical form by me is true and accurate. I will not hold Honey Bee Nursery responsible for any accidents or incidents that will occur due to any medical information not provided by me.

Honey Bee Nursery reserves the right to administer first aid and any emergency treatment as required. Parents/guardians will be informed of all the accidents and will require signing an accident form. For accidents of serious nature, involving hospital treatment, all attempts will be made by the nursery to contact the parent. But failing this we are hereby authorized to act on behalf of the parent/guardian and authorize necessary treatment. The parent/guardian will bear the cost or expense incurred for any treatment or services.

Parents/Care’s Full Name: _____Date: _____

Signature: _____Email: _____