

1. CHILD INFORMATION

First Name:

Family Name:

Birth Date:

dd/mm/yyyy

/ /

2. HAS YOUR CHILD RECEIVED THE FOLLOWING VACCINATIONS?

BCG	YES <input type="checkbox"/>	NO <input type="checkbox"/>	*DPT/Polio (3-4 Years)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
*Diphtheria, Pertussis, Tetanus (DPT)/ Polio /Hib(2,3,4 months)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	*MMR (12 months and 3-4 Years)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
*Meningococcus (3,4,12 months)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Varicella (12 months and 4-6 Years)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
*Haemophilus influenzae (hib)(12 months)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hepatitis A (12 -24 months/2 doses)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Pneumococcal (2, 4, 12 months)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hepatitis B	YES <input type="checkbox"/>	NO <input type="checkbox"/>
			Other (Specify):	YES <input type="checkbox"/>	NO <input type="checkbox"/>

* Indicate British Standards Immunizations

3. HAS YOUR CHILD HAD ANY OF THE FOLLOWING ILLNESSES OR SUFFER FROM ANY OF THESE CONDITIONS?

Chicken Pox	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Frequent Colds/ Sinusitis/H1N1	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Whooping Cough	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Fainting	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Measles	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Asthma	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Mumps	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Fever (any)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tuberculosis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Heart Trouble	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Pneumonia	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Operations (Specify)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Poliomyelitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Serious Injuries (Specify)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tonsillitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Other (Specify)	YES <input type="checkbox"/>	NO <input type="checkbox"/>

NOTES:

4. DOES YOUR CHILD HAVE ANY VISION / HEARING IMPAIRMENTS OR LEARNING DIFFICULTIES?

YES
NO

Give detail, if YES:

5. DOES YOUR CHILD HAVE ANY RESPIRATORY DIFFICULTIES, PHYSICAL DISABILITY OR OTHER REASON TO HAVE RESTRICTED PHYSICAL ACTIVITY?

YES
NO

Give detail, if YES:

6. DOES YOUR CHILD HAVE ANY OTHER HEALTH ISSUE OR REQUIRE ANY SPECIAL MONITORING?

YES
NO

Give detail, if YES:

7. DOES YOUR CHILD HAVE ANY ALLERGIES OR FOOD RESTRICTIONS?

YES
NO

Give detail, if YES:

8. CALPOL POLICY/MEDICAL & MEDICINE ADMINISTRATION

Children who are not well should not attend nursery. The nursery program is active and involved so if they need rest or fever reducers, children must be kept at home. I agree that the school may administer Calpol/pain relief medication should it be required. The school will endeavour to telephone me should this be required. Any other medication may be administered as required in emergency or, subject to the signing off by the Parent of the Medicine Administering Form and doctors prescription attached which must be completed by Parent prior to any medication being left on premises.

Date: _____ Signature of Parent / Guardian: _____

9. NURSERY HEALTH POLICY/EMERGENCY TREATMENT

Children who are not well should not attend Nursery and remain away until fully clear of illness / infection. To reduce the risk of cross infection, I agree to abide by the Nursery Health Policy which outlines the requisite time away from the nursery, subject to change. In the event of an emergency, I agree to the School Nurse, and / or any member of staff providing emergency care including, if required calling an ambulance or calling in medical attention. If called in for a medical reason, I will endeavour to be at the nursery to collect my child within a maximum 1 hour and in no event after closing time. I agree that I will be responsible for any and all costs incurred and take full responsibility for treatment required and hold the nursery and its staff harmless in the event that we are unable to reach the parent and / or emergency contact to confirm the course of action to take. I agree to the Nursery Terms and Conditions and agree to be bound by them.

Date: _____ Signature of Parent / Guardian: _____

10. CHILD'S FAMILY DOCTOR INFORMATION

Doctor's name	Emergency No.:
Telephone No.:	Mobile :
Health Ins. Co.:	Health Card No.:

11. PARENTAL UPDATE OF INFORMATION

I hereby confirm that all the above medical information is accurate and correct to the best of my knowledge. I endeavour to provide Blossom Children's Nursery with any changes to this information as and when I become aware of them and have attached my child's updated immunization form to this completed questionnaire.

Date: _____ Signature of Parent/Guardian: _____

FOR INTERNAL USE:

Date Received: _____ Signature: _____ Follow up: _____