Woodlands Pre-school

Initial..... Surname.....

Medical Information

Name of child		Name known as		
Date of birth		Gender	Male	Female
Name of parent(s)		1st Language		
		Home Number		
Address		Mobile Number		

EMERGENCY CONTACT DETAILS				
Mothers Contact	Work :-		Mobile:-	
Fathers Contact	Work:-		Mobile:-	
Mothers Work Address:-			Fathers Work Address:-	
Other Contacts Name			Relationship To child	
Mobile Number Home Number			Address	

DOCTORS DETAILS			
Practice name		Name of Doctor	
Address		Telephone Number	

Immunizations (Please indicate which injections your child has received)

Tetanus	Diphtheria	Measles	Mumps	Whooping cough	Rubella	Polio	Meningitis

Does your child have any allergies? I.e:- Milk, nuts etc	Yes	No	Details If yes	

Medical Conditions (please indicate can conditions your child may have)

Asthma	Eczema	Diabetes	Sight Impairment	Blood Disorders	Hearing Impairment	Physical Disabilities

Cerebral Palsy	Epilepsy	Any other :- (Including Allergies)

Is your child registered disabled?	Yes	No
Does your child have any special needs	Yes	No
Any Other Information we need to know?		

Please read each of the following statements and tick the box if you agree.

- ☐ I give permission for hypoallergenic plasters to be used on my child.
- ☐ I give permission for my child to drink milk.
- ☐ I will inform the Pre-school of any existing injuries before leaving them.
- ☐ I will not bring my child back to setting if He/She has not fully recovered from an infectious virus, skin or eye complaint (including sickness and diarrhoea – 72 hours from last episode)
- ☐ I give permission for staff to act on behalf in a medical emergency when I or any other individuals on this form can't be contacted.

By ticking the boxes above you in agreement with our terms and conditions .

Signature : _____ Date_____