



Passport sized
photograph
of child

Child's Paediatrician Details

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

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;

