Daffodils Nursery دافوديلز نرسري

MEDICAL FORM

Child's Name: ……. **Class : ……**

Date of Birth : ……. **Blood Group : …….**

Please complete the following tables:

Does your child suffer from any of these diseases:	**NO**	**YES**	**If (Yes) please specify the Medication**
Epilepsy			
Bronchial Asthma			
Heart Disease			
Allergy to any medicine			

Did your child suffer from any of the following illness in the past?	**NO**	**YES**
Chicken Pox		
Measles		
Mumps		
Scarlett Fever		
COVID-19		
If yes for the above question, please specify the start and end date		

Does your child follow a vegetarian diet? YES ☐ NO ☐

Does your child have any known allergies? YES ☐ NO ☐

If Yes, please specify:

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Signature of Parent **Date**