Daffodils Nursery دافوديلز نرسري

MEDICAL FORM

Child's Name: ……………………………………. **Blood Group: ………………………………….**

Date of Birth: ……………………………………….

Does your child suffer from any of these diseases:	**YES**	**NO**	**If yes, please specify the medication**
Epilepsy			
Bronchial Asthma			
Heart Disease			
Allergy to any medicine			
Is your child fully immunized in accordance with the Ministry of Health in Qatar?			
Is your child taking any medication?(If yes,pls mention the name & purpose)			

Did your child suffer from any of the following illness in the past?	**YES**	**NO**
Chicken Pox		
Measles		
Mumps		
Scarlett Fever		
COVID-19 (If yes, please specify the start and end date)		
Please confirm if your child currently has Head Lice & Nits(If yes, please note that the scalp must be clear of lice and nits before joining the nursery)		

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 …………………………………. **Date ……………………….**

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