Personal & Medical History

Centre Name	**The Treehouse Kids Nursery School**		
Child's Name			
Doctor's Name		**Tel**	
Doctor's address			
Medical Aid	**Scheme name:** _____ **Medical Aid number:** _____ **Main member:** _____ **Main member contact number:** _____		

Emergency contacts:		
Name	**Relationship to child**	**Tel**

Health Information: Does your child have? Explain why if Yes		
Frequent colds	**Yes** ☐ **No** ☐	
Earaches	**Yes** ☐ **No** ☐	
Stomach aches	**Yes** ☐ **No** ☐	
Nosebleeds	**Yes** ☐ **No** ☐	
Vomiting often	**Yes** ☐ **No** ☐	

Does your child have any disabilities/learning barriers? If yes, please list details			
Has your child had any of the following diseases/illnesses/medical conditions?			
Measles	**Yes ☐ No ☐**	**German Measles**	**Yes ☐ No ☐**
Heart Disease	**Yes ☐ No ☐**	**Scarlet Fever**	**Yes ☐ No ☐**
Rheumatic Cough	**Yes ☐ No ☐**	**Kidney Disease**	**Yes ☐ No ☐**
Whooping Cough	**Yes ☐ No ☐**	**Diabetes**	**Yes ☐ No ☐**
Mumps	**Yes ☐ No ☐**	**Hepatitis**	**Yes ☐ No ☐**
Pneumonia	**Yes ☐ No ☐**	**Convulsions**	**Yes ☐ No ☐**
Chicken Pox	**Yes ☐ No ☐**	**Epilepsy**	**Yes ☐ No ☐**
Other:			
Does your child suffer from any allergies? If yes, please list details			

General health	
Has your child had their vision tested?	**Yes** ☐ **No** ☐
Has your child had their hearing tested?	**Yes** ☐ **No** ☐
Does your child have speech problems?	**Yes** ☐ **No** ☐
Does your child prefer:	
Busy and on the go all the time	**Yes** ☐ **No** ☐
Sometimes active, sometimes quiet	**Yes** ☐ **No** ☐
Mostly quiet and inactive	**Yes** ☐ **No** ☐

Family

Names of other children in the family (in order)

Name	Birthdate	Gender
Position of this child in family?		