The Wonder Years Early Childhood Centre

www.wonderyearsecc.com

MEDICAL FORM 1

CHILDS INFORMATION

Academic Year: _____

Full Name: _____

Gender: _____ Date of Birth: _____

EMERGENCY CONTACT INFORMATION

In case of an emergency, if parents cannot be reached, please provide 2 emergency contacts:

Name: _____ Name: _____

Relationship: _____ Relationship:_____

Contact No(s): _____ Contact No(s): _____

FAMILY PHYSICIAN INFORMATION

Doctors Name: _____ Contact No(s): _____

Medical Practice/Clinic: _____ Address: _____

HEALTH INSURANCE INFORMATION

Is your child covered by health care insurance? _____ If yes, please provide the following details:

Health Insurance Co. _____ Health Insurance Card No: _____

(Please also attach a photocopy of your child's health insurance card)

Does your child have a UAE Health Card: _____

If yes, please attach a photocopy of your child's UAE Health Card.

MEDICAL HISTORY

Does your child have any of the following medical issues?

	Yes	No	Details (if any)
Allergies			
Other Food Intolerances/Dietary Restrictions			
Asthma/Other Respiratory Difficulties			
Hay Fever/Sinusitis			
Eczema/Skin Disordes			
Epilepsy			
Diabetes			
Heart Problems			
Vision/Hearing Impairment			
Physical/Mental Disability			
Special Learning Needs			
Any Other Health Issues			