



MEDICAL FORM 2

Does your child take any regular medication? _____

If yes, please give details _____

Has your child ever been hospitalised or undergone surgery? _____

If yes, please give details _____

Has your child received any recent medical treatment? _____

If yes, please give details _____

Has your child ever suffered from any of the following?

Illness	Yes	No	Date	Illness	Yes	No	Date
Chicken Pox				Pneumonia			
Diphtheria				Tonsillitis			
Dysentery				Rheumatic Fever			
Fainting Illness				Rubella			
Foot and Mouth				Scarlet Fever			
Hepatitis				Strep Throat			
Measles				Swine Flu (H1N1)			
Mumps				Tuberculosis			
Polio				Whooping Cough			
Others:				Others:			

VACCINATION FORM

Has your child received the following vaccinations? Please tick (to indicate no) the box, as appropriate.

Tuberculosis (BCG)	Birth				
Hepatitis B	Birth	2 months	6 months		
DTAP, DT	2 months	4 months	6 months	18 months	3-5 years
HIB	2 months	4 months	6 months	18 months	
Polio (IPV)	2 months	4 months	6 months	18 months	3-5 years
Pneumococcal (PCV)	2 months	4 months	6 months	18 months	
MMR			12 months		3-5 years
Varicella			12 months		3-5 years
Hepatitis A			12-18 months	18-24 months	
Meningococcal					
Flu					

I hereby confirm that all the above medical information is correct and accurate, to the best of my knowledge.

I agree to provide The Wonder Years ECC with any changes to this information as and when I become aware of them.
I have attached my child's most up-to-date immunisation records, as requested.

Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____