LEGACY EARLY YEARS
love learning

CONFIDENTIAL

Student Name : _____

Grade : _____

Gender : _____

Date of Birth : _____

Blood Type : _____

HEALTH & MEDICAL QUESTIONNAIRE

Parent 1	Parent 2	Emergency Contact (Other than the parent)	Child

EMERGENCY CONTACT INFORMATION

Family Doctor : _____ Mobile : _____

Preferred Hospital / Clinic : _____ Phone : _____

Insurance Provider _____ Policy No. _____ Expiration _____

Parent 1 : _____ Mobile : _____
First Name *Last Name*

Parent 2 : _____ Mobile : _____
First Name *Last Name*

Local emergency contact : _____ Mobile : _____
(Other than the parent) *First Name* *Last Name*

Home Address : _____
House / Apartment Number and Name *Street Address*

_____
Town / Area *City* *State / Province* *Postal / Zip Code* *Country*

VACCINATION RECORD

Vaccine	Vaccine Dates				
BCG					
Chicken pox					
Hepatitis A					
Hepatitis B					
Measles					
Mumps					
Rubella					
Polio					
Tetanus					
Other _____					

HEALTH & MEDICAL QUESTIONNAIRE

Please indicate below if your child has experienced or is still experiencing any of the following?

Allergies (Mild)	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Allergies (Severe)	☐ No	☐ Yes	Anxiety / Panic attack	☐ No	☐ Yes
Skin allergy	☐ No	☐ Yes	Cardiac related illness	☐ No	☐ Yes
Hearing impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Visual impairment	☐ No	☐ Yes	Hypertension / Stress	☐ No	☐ Yes
Speech impediment	☐ No	☐ Yes	Respiratory illness	☐ No	☐ Yes
Neuromuscular condition	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Physical challenges	☐ No	☐ Yes	Emotional difficulties	☐ No	☐ Yes
Behavioural challenges	☐ No	☐ Yes			
Other (please specify)	☐ No	☐ Yes	_____		

Is your child allergic to any medication?	☐ No	☐ Yes
Can your child be given any medication by the school for common illnesses?	☐ No	☐ Yes
Does your child take any prescribed medication regularly?	☐ No	☐ Yes
Have your child's developmental milestones been age appropriate?	☐ No	☐ Yes
Is there any other important information concerning your child's health?	☐ No	☐ Yes

List any special dietary needs / preferences : _____

Note : *Please provide details on a separate sheet if you have indicated **'Yes'** to any of the questions above.*

DISCLAIMER :

- The information provided above is certified to be true to the best of our knowledge.
- In the event of an emergency, we authorize Legacy Early Years to take any action that is deemed to be in the best interest of our child in consultation with the medical practitioner concerned.
- We agree to reimburse Legacy Early Years for any medical treatment that our child may receive.

Name of Parent 1 : _____ **Signature :**_____ **Date :** _____

Name of Parent 2 : _____ **Signature :**_____ **Date :** _____

Note: This form is to be completed and submitted along with the student's application form at the time of admission.