C close, 34 Road, Gowon estate,
Egbeda, Lagos.
+2347087290841
www.kiddiesoasis.com.ng
info.kiddiesoasis@gmail.com

MEDICAL FORM

Please correctly fill this form. The information requested will be maintained under strict confidentiality, and shall only be disclosed to the authorized licensed consultant with your prior approval.

CHILD'S NAME (FIRST, MIDDLE, LAST)	ADDRESS	
TELEPHONE	CHILD'S AGE	CHILD'S WEIGHT

PARENT INFORMATION	**PARENT/GUARDIAN**	**PARENT/GUARDIAN**
NAME		
MOBILE PHONE		
PLACE OF EMPLOYMENT		
ADDRESS OF EMPLOYMENT		
WORK TELEPHONE		
HOME ADDRESS		
HOME PHONE		

CHILD'S HEIGHT	BLOOD GROUP	GENOTYPE
ALLERGIES	1. 3. 5.	2. 4. 6.
ANY EXISTING MEDICAL CONDITION(S)	1. 3. 5.	2. 4. 6.
PRESCRIBED MEDICATION (IF ANY)	1. 3. 5.	2. 4. 6.

NON-PRESCRIPTIVE MEDICATION (OINMENT, LOTINS, E.T.C)	1. 2. 3. 4. 5. 6.

INFANTS

ARE THE IMMUNIZATIONS/VACCINATIONS COMPLITED? If no which ones are left?	

PHYSICIAN AND PRIMARY CARE PROVIDER

NAME	PHYSICIAN	HEALTH CARE PROVIDER (hospital/clinic)
ADDRESS		
TELEPHONE		
MOBILE PHONE		

EMERGENCY CONTACTS (in case of medical emergency)

	CONTACT 1	CONTACT 2
NAME		
ADDRESS		
MOBILE NUMBER		

RELATIONSHIP TO CHILD		

SPECIAL DIRECTIONS OR NOTES:

_____

_____

_____

PLEASE FILL THE INFORMATION BELOW, IF AVAILABLE.

Insurance carrier: _____

Account number: _____ ID number: _____

AUTHORIZATION

We hereby understand and agree to the required information above, and authorize any administration of any prescriptive or non-prescriptive medication as stated above.

Parent/Guardian Signature: _____ Date: _____