



KAY-DEE EDUCARE CENTRE CC

(Registration no. 1996/008545/23)
 Registered Address: 1 Richmond Road, Mowbray 7700
 Business Address: Hillpark Lane, Mowbray 7700
 Telephone: (021) 689 9615
 Direct Fax: 086 561 9556 / Cell No. 082 890 0555
 Email: kaydee@kaydee.co.za
 Website: www.kaydee.co.za









MEDICAL INFORMATION FORM BABIES TO GRADE R/0

**Medical
Forms**

1. PERSONAL DETAILS OF CHILD:

(Please use block letters)

| | | | |
|--|--|--|--|
| SURNAME: | | TITLE: | GENDER: |
| FIRST NAMES: | | DATE OF BIRTH: | IDENTITY NUMBER: (on Birth Certificate) |
| NUMBER OF CHILDREN in Household / Family: | | | |
| NAME OF MEDICAL AID (if applicable): | | MEDICAL AID NO: | DEPENDENT NO: |
| SCHEME: | | PRINCIPAL MEMBER: | |
| RELIGION (for blood transfusions): | | ALLERGIES: | |
| ROAD TO HEALTH CARD (handed in to Kay-Dee?): | | CHRONIC ILLNESS/ES: | |
| CLINIC NAME (if applicable): _____ FAMILY DOCTOR NAME: _____ PRACTICE NUMBER: _____  TEL NO: _____ | | PHYSICAL ADDRESS OF DOCTOR: _____ _____ _____  | |
| IN CASE OF EMERGENCY: (Please provide contact name and numbers of next of kin / family / friend) NAME: _____ RELATIONSHIP: _____  TEL NO: _____  CELL NO: _____ | | IN CASE OF EMERGENCY: (Please provide contact name and numbers of next of kin / family / friend) NAME: _____ RELATIONSHIP: _____  TEL NO: _____  CELL NO: _____ | |

I/WE ACKNOWLEDGE THAT THIS MEDICAL INFORMATION FORM WILL BE TREATED AS CONFIDENTIAL AND ALL INFORMATION PROVIDED IS TRUE AND CORRECT.

PARENT/GUARDIAN SIGNATURE: _____

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2. IMPORTANT MEDICAL INFORMATION:

| | |
|--|---------------------------------|
| Has the child had any serious accidents? YES / NO | Please explain if YES: |
| Has the child had any operations / medical procedures? YES / NO | If YES, please provide details: |
| Any other medical information that might be needed in a medical emergency: | |
| CURRENT MEDICATION NAME/S (if applicable & dosage): | |
| PERMANENT MEDICATION NAME/S (if applicable): | |
| PRE-EXISTING CONDITION/S (if applicable - example diabetes, etc. that medication is required for): | |
| Has your child had all the necessary vaccinations / inoculations? YES / NO | Please explain: |

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3. STATE WHETHER YOUR CHILD HAS CONTRACTED THE FOLLOWING DISEASES LISTED BELOW AND WHEN (DATE):

(If your child has NOT had any of the diseases listed below, please state NO.)

| DISEASES | YES or NO | DATE OF OCCURRENCE |
|--|-----------|--------------------|
| Whooping Cough | | |
| German Measles / Rubella | | |
| Smallpox | | |
| Chickenpox | | |
| Polio | | |
| Scarlet fever | | |
| Diphtheria | | |
| Mumps | | |
| TB | | |
| AIDS / HIV (please state if she / he is on antiretroviral) | | |
| Meningitis | | |
| Hepatitis A, B or C | | |

- Pre-existing conditions (e.g. diabetes) are important for paramedics and doctors to know about.
- It is important to update this part of the form and to inform Kay-Dee about updates.

4. IF YOUR CHILD IS ALLERGIC TO ANY FORM OF MEDICATION (eg. PENICILLIN), INJECTIONS, TABLETS, POLLEN, GRASS, FOODS, etc.), PLEASE STATE BELOW HOW IT MANIFESTS ITSELF.

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5. IN CASE OF EMERGENCIES, IF YOUR CHILD HAS AN INJURY THAT REQUIRES MEDICAL TREATMENT SUCH AS STITCHES, BROKEN BONES, FRACTURES, etc., MAY HE / SHE BE TAKEN FOR TREATMENT TO A HOSPITAL OR TO A DOCTOR? PLEASE STATE YES OR NO. IF NO, STATE REASON THEREOF.
 (The Parents / Guardian WILL be notified prior to us going ahead with treatment.)

6. IF YOUR CHILD IS PRONE TO DEVELOP THE FOLLOWING ON A REGULAR BASIS, KINDLY INDICATE HOW OFTEN:

| FREQUENT ALIMENTS | FREQUENCY |
|------------------------|-----------|
| Colds | |
| Tonsillitis | |
| Ear aches | |
| Stomach aches | |
| Asthma | |
| Hay-fever | |
| Hives | |
| Other (please specify) | |

- Please remember to send a detailed report with all assessments that your child has received from the relevant doctor's psychologists, therapists, etc.
- We require a doctor's proof of medication to be administered daily, if applicable.

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7. CHILD HEALTH INFORMATION:

| HAS THE CHILD | YES or NO | OUTCOME COMMENTS |
|---|-----------|------------------------------|
| Been to see a dentist? | | |
| Eyes been tested? (Copy of visual screening results required, if applicable) | | |
| Wears or in need of glasses? | | State wears or in need: |
| Has had a hearing test? (Copy of auditory screening results required, if applicable) | | |
| Tested for ADD / ADHD? (Copy of test outcomes to be attached, if applicable) | | |
| Wears corrective shoes? | | Reason: |
| Does the child have any speech problems or undergoing speech therapy? | | State how often and reason: |
| Undergoing physiotherapy, occupational therapy (OT), or other treatments? | | State therapy and treatment: |
| Been diagnosed or suspected of having any of the following disorders: Autism, ADHD, ADD, Bipolar, Asperger's Disease, Edwards Disease, etc.? Please state which one below: Copies of assessments from doctors, psychologists, etc. must accompany this form. Please note that all correspondence is held as highly confidential. | | Diagnosis: |

8. MEDICAL MATTERS:

- 8.1 The staff at Kay-Dee Educare undergo training and do a refresher course every two years in FIRST AID / CPR.
- 8.2 Children who are ill MAY NOT be brought to school especially under the following conditions:
- 8.2.1 Within 12 hours of a high temperature
 - 8.2.2 Within 48 hours of going onto an antibiotic
 - 8.2.3 Spots and rashes
 - 8.2.4 Ringworm and impetigo
 - 8.2.5 Sore throats, especially tonsillitis
 - 8.2.6 Infected eyes
 - 8.2.7 ANY runny tummy

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- 8.2.8 Vomiting
- 8.2.9 Yellow, green or brown runny noses
- 8.2.10 Weeping ears
- 8.2.11 LICE – a clinic or doctors certificate is required stating that your child’s free from lice and nits before he/she may return to school
- 8.3 When a child has been on an antibiotic for 48 hours and deemed well enough to return to school (and not contagious to others), the school will administer the remainder of the antibiotic at appropriate times.
- 8.4 If a child is to receive medicine during the course of the day, the parent/guardian fills in and signs the MEDICATION REGISTER on dropping off the child
- 8.5 Children may not carry their own medicines into school
- 8.6 Medicines may not be left in the child’s bag but handed to the teacher
- 8.7 It is the parent/guardian’s responsibility to remember to collect the medication from the teacher/antibiotics kept in the fridge
- 8.8 Without the Medication Register having been PROPERLY filled out and signed, no medication will be administered to that child. Instruction will not be taken over the telephone or from the communications book
- 8.9 Parents will find a copy of the Medication to be administered form in the back of the child’s communication book. IF their child/ren come to school via other transport or taxi
- 8.10 THIS ONLY APPLIES TO PARENTS WHO DO NOT DROP THEIR CHILDREN OFF PERSONALLY!
- 8.11 If a child appears or gets sick at school, we will contact the parent/guardian and the parent/guardian must make immediate arrangements to collect their child.
- 8.12 If a parent/guardian can not take time-off from work, they must organise with a friend, grandparent, etc. or a responsible person to collect their child in the event of sickness.
- 8.13 BEE STING ALLERGIES: If your child is allergic to bee stings, the parent/guardian must leave a bottle of Antihistamine at Kay-Dee Educare. When this expires, the parent/guardian replaces it.
- 8.14 A doctor’s certificate is to accompany the child on return to Kay-Dee, stating illness and condition and day of safety to return to Kay-Dee Educare Centre in the event of any sickness.
- 8.15 SICK CHILDREN BELONG AT HOME AND NEED TENDER LOVING CARE.

9. ADDITIONAL IMPORTANT INFORMATION TO BE COMPLETED IN FULL:

| |
|---|
| Does the child sleep alone, sleep with parents, share a room with others (please state with who below): |
| Has the child had any playgroup experience? Please explain: |
| Does the child have any problems which we should be aware of? |
| How would you describe your child’s personality? |

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Are there any special family circumstances which may be a factor in your child's present behaviour, such as divorce, death, new baby, recent move, hospitalization? Please explain:

What concerns do you have about your child's present behaviour?

What are you doing about these concerns?

In what ways would you like to see your child develop during this year in our program?

Please add any comments that you feel will help us know your child better:

10. COMPLETE THE FOLLOWING:

List the TELEVISION programmes your child watches.

When and with whom does your child watch TELEVISION?

Neighbourhood playmates? Specify:

Prefers to play alone, with playmates, or siblings?

Imaginary playmates / friends?

Pets? State what type and how many and if your child has any pet allergies:

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Favourite outdoor activities?

Favourite indoor activities?

Favourite toys, play equipment and books?

Left-handed, right-handed or ambidextrous?

Good, average or poor eater?

For which meal is the child mostly hungry?

Breakfast

Lunch

Supper

Feeds self, or waits to be fed?

Naps during the day and when?

Decides for him- / herself when to go to the bathroom or is a reminder needed?

Word or phrase child uses for urination:

Word or phrase child uses for bowl movement:

Usual time for bowel movement(s):

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Areas needing ongoing support (eg. Academic, emotional, behaviour, social, learning, vision, mobility, communication, etc.):

11. MILESTONES:

(It is important to fill this section out no matter how old your child is, as this section will show if your child will portray any developmental delays if not reached at the correct age.)

| State when your child | Answer |
|---------------------------------|--------|
| First crept on hands and knees? | |
| Sat without help? | |
| Walked without help? | |
| Named simple objects? | |
| Repeated short sentences? | |
| Slept through the night? | |
| Began toilet training? | |

12. KINDLY COMPLETE THE FOLLOWING IN ACCORDANCE WITH YOUR CHILD'S AGE GROUP / CAPABILITIES:

| IS YOUR CHILD: | PARENT COMMENTS |
|--|-----------------|
| Responsible? | |
| Does he / she maintain eye contact when spoken to? | |
| Interaction with unfamiliar adults? | |
| Interaction with unfamiliar children? | |
| Responds to gestures such as "blowing kisses", "clap hands", "stamp feet", etc.) | |

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| | |
|--|--|
| How do you view your child's concentration (if applicable)? | |
| Offers conversational responses such as "What is your name?", "What are you doing?" | |
| Responds to "NO"? | |
| Gets upset easily? | |
| Reaction when angry? | |
| Sleep difficulties? | |
| Obeys instructions? | |
| Respectful towards adults? | |
| Respectful towards peers? | |
| Independent? (eg. Feeds self, dresses / undresses self, puts on own shoes, etc. if applicable) | |
| Defiant? | |
| Attention seeking? | |
| Helpful? (eg. Picks up toys, etc.) | |

Thus done and signed at _____ (Place) on the ____ day of _____ (Month) 20____ (Year)

 Mother / Guardian Signature

 Father / Guardian Signature

ODETTE LEACH
SCHOOL HEAD / PRINCIPAL
KAY-DEE EDUCARE CENTRE CC

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