Child Medical Report form

Child Information		
First name:	Middle name:	Last name:
Date of Birth:	Gender:	Nationality:

Does your child suffer from any of the below diseases

- ○ Asthma
- ○ Cardiac disease
- ○ Diabetes
- ○ Hypertension
- ○ Psychiatric disorder
- ○ Allergy
- ○ Others

  …….

Does your child suffer from any medication allergies

- ○ Yes
- ○ No

I …… the guardian of …… by signing below I certify that this is a legally binding form. Provided by my child's physician.

Physician Signature:_____