CHILD HEALTH INFORMATION

Identifying Information

Child's Name:_____ Date of Birth:_____

Child's Address:_____

_____

Family Physician's Name:_____ Telephone Number:_____

Physician's Address:_____

Immunizations

Are your child's immunizations up to date? Y N

Please give a copy of your child's immunization cad to a day nursery staff member of complete the "Child Immunization Record" form.

Previous Illnesses or Injuries

(Ex. Chickenpox, operations, broken limbs)

_____

_____

_____

Health Conditions

Does your child have special health conditions including physical or mental challenges? Y N

If yes, complete the "Detailed Health Information" form.

Allergies

(ex. To food, medications or environment)

Yes _____ None known

Does your child require any medication for this allergy? Y N

If yes, complete the "Detailed Health Information" form (over)

Special Requirements

(for diet, exercise or rest)

_____ _____ _____

Parent's Name (print) Signature Date (d/m/y)