Medical Information Form

Child Name ______________________, ________________ Last Name First Name	Date of Birth ________________ MM / DD / YYYY

Child's Physician ______________________, ______________________________, ________________
Name Address Telephone Number

Child's Health Card Number ____

1. Are all immunization requirements met?
   □ YES □ NO
   ____
   ____

2. Has your child had any of the following illnesses or injuries?
   □ Mumps □ Measles □ Whooping Cough □ Scarlett Fever □ German Fever □ Chicken Pox

3. Does your child have any special medical conditions or special needs (including behavioral)?
   □ YES □ NO
   If yes, please specify
   ____
   ____

4. Does your child have any allergies?
   □ YES □ NO

   * If yes, please complete the Child Allergy and Health History Form

5. Does your child take any medication on a regular OR emergency basis?
   □ YES □ NO □ PUFFER □ EPIPEN

   * If yes, please complete the Child Allergy and Health History Form

6. Does your child have any special requirements regarding diet, rest needs, exercise abilities or in any other area?
   □ YES □ NO