Date: _____/_____/_____
Year Month Day

Child's Name: _____
Date of Birth: _____/_____/_____
Year Month Day

Personal Health Number: _____
Group Medical Services: _____
(OR Medical Services Inc. Number)

Mother's Name: _____
Address: _____
Postal Code: _____
Home Phone: _____
Business Phone: _____
Email: _____

Father's Name: _____
Address: _____
Postal Code: _____
Home Phone: _____
Business Phone: _____
Email: _____

Emergency Contacts *(MUST HAVE TWO)*

Name: _____
Relationship: _____
Address: _____
Home Phone: _____
Business Phone: _____

Name: _____
Relationship: _____
Address: _____
Home Phone: _____
Business Phone: _____

Physician's Name: _____ Phone: _____

Address: _____

Check (✓) any and all of the following illnesses that your child has had:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Croup
- ☐ Diphtheria
- ☐ Earaches
- ☐ Eczema
- ☐ Frequent Colds
- ☐ Influenza
- ☐ Injuries
- ☐ Measles (German)
- ☐ Measles (Red)
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tonsillitis
- ☐ Whooping Cough
- ☐ Other: _____
_____
_____

List all known allergies (If none, please write "None Known"):

Drug:	Food:	Other:
_____	_____	_____
_____	_____	_____

List all medications taken on a regular basis:

_____
_____
_____
_____

List all known medical conditions:

_____
_____
_____
_____

List any concerns/limitations in regards to this child's medical treatment:

_____
_____
_____
_____

Other comments:

_____
_____
_____
_____

_____
Parent/Guardian Signature

Date: _____/_____/_____
Year Month Day

_____
Executive Director

Date: _____/_____/_____
Year Month Day