HEALTH HISTORY FORM

****TO BE COMPLETED PRIOR TO ENTRY TO DAY NURSERY****

Name of Daycare: _____

MEDICAL HISTORY

Name of Child: _____ **Date of Birth: _____**
Address: _____ **Country of Birth: _____**
_____ **Health Card No.: _____**
Telephone Number: _____

Mother: _____ **Father: _____**
Telephone Number: _____ **Telephone Number: _____**

Does your child have any condition(s) or behavior that would require a special attention, medication or a special diet? If yes please explain.

_____
_____
_____

Allergies? (Food, Medication, etc.) IF YOUR CHILD HAS FOOD ALLERGIES WE MUST HAVE A LIST SIGNED BY YOUR DOCTOR STATING WHAT HE/SHE CAN/CANNOT HAVE.

_____
_____

Name of Child's Doctor: _____
Full Address: _____
Telephone Number: _____

PARENT/GUARDIAN SIGNATURE: _____
DATE: _____

****In circumstances such as accident or sudden illnesses, emergency treatment may be given by any Doctor. Child may be transported for any such emergency treatment. YES ___ NO ____**