



ELM CHILDRENS CENTRE
162 MAIN, STREET.
GLENCOE, ONTARIO
NOL 1MO

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 ___