MEDICAL RECORD

Name of Child: _____ Date of Birth: _____

Copy of immunization record attached: Yes / No
Any statement from a parent of MD as to why child should not be immunized: Yes / No

Child's previous history of communicable disease: Yes / No

If yes please state: _____

Any Symptoms indicative of ill health? Yes / No

If yes please state: _____

Child's special requirement in respect of diet? Yes / No
Allergies: _____

Anaphylactic: Yes / No _____
A plan will be in place and posted for any child using an epi-pen. All epi-pens must come with a pharmacist label in original boxing.

Restriction due to religious reasons? Yes / No If yes please state: _____

Child's special requirement in respect to rest? Yes / No If yes please state: _____

Child's special requirement in respect to exercise? Yes / No If yes please state: _____

Any special medical condition? Yes / No If yes please state: _____

Doctor's Info

Name:	Phone #:
Address:	Postal Code:

Notes:
1. Please provide signed written instructions for any medical treatment, drug or medication to be administered during hours child receive care.
2. Our centre is allowed to be administered **only** prescriptions. For over-the-counter drugs, please provide a doctor's note indicating the name of the medicine, the time and amount to be administered.
3. Please keep your child home if he or she has a fever of 37.8 C or over, diarrhea, vomiting, unexplained rashes, paleness, flushed face, constant crying or yellow discharge from the eye.
4. If your child is suspected of having a contagious disease, the child must not be in the centre. Please notify us if your child is kept home due to illness or any communicable disease.
5. If symptoms develop during the day the parents will be called and asked to take child home immediately.
6. If any emergency medical treatment is required due to circumstances as accidents, sudden illness or other emergency, we will call 911 on your behalf for medical treatment.

Parent's Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____