



CARING FOR KIDS PRIVATE HOME DAYCARE MEDICAL FORM

CHILD INFORMATION

Surname: _____ Male Female
 Given Name(S): _____ Birth Date: _____ (D/M/Y)

DOCTOR/MEDICAL INFORMATION

Doctor's Name _____
 Address: _____
 Apt/Unit #: _____ City/Town: _____ Province: _____
 Postal Code: _____ Telephone Number: _____

HISTORY OF COMMUNICABLE DISEASE

- Chicken Pox Mumps Measles Whooping Cough Rubella (German measles)
 Hepatitis Scarlet Fever

IMMUNIZATION SCHEDULE

A copy of your child's yellow immunization schedule **MUST** be provided before starting Daycare.

DPTP-HIB4

MMR

2 months	4 months	6 months	18 months	4-6 year booster	12months	18 months or 5 year

ALLERGIES: If your child has an allergy(ies), please indicate below:

Allergy	Mild	Moderate	Severe	Life Threatening

If your child has a life threatening allergy please fill out Anaphylactic Action Plan prior to start date (**please ask Consultant for copy**).

MEDICAL CONDITIONS: If your child has asthma or any other medical condition such as epilepsy, diabetes, disabilities or reactions to drugs which could be a complicating factor (please inform Consultant).

MEDICATIONS: Is your child on any regular prescription medication? If yes, please describe _____

Date: _____ Signature of Parent/Guardian: _____