

Last Name: _____ Date of Birth: ___/___/___
 First Name(s): _____ d m y
 Health Number: _____
 Civic Address: _____ Phone #: _____
 PO Box: _____
 Town/P.Code _____

Email Address: _____

Parent/Guardian's Name(s): _____

Does your child have any of the following problems?

- Allergies Skin Problems ADHD/ADD
- Asthma Frequent Ear Infections
- Other: _____

Medications: Please list all the medications that your child regularly takes:

Allergies: Please list all drug allergies.

Do you regularly give your child vitamins or other nutritional supplements?

- yes no Which ones? _____

Do you usually have your child come in for a yearly physical examination?

- yes no Date of last exam _____