Medical Information Form

Doctor's Name: ______________________________ Doctor's Number: ____________

Doctor's Address: ____________________________________ Postal code: __________

1. Did your child had their vision checked? ☐ Y ☐ N
2. Did your child had their hearing checked? ☐ Y ☐ N
3. Did your child had their dental check-up? ☐ Y ☐ N
4. Please indicate if your child has any health problems: ____________________________________

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5. Please indicate if your child is under treatment for any illness or injury, and if it will interfere with any activities: ____________________________________

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6. Please indicate if your child needs extra help/attention: ____________________________________

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7. Please indicate if your child has any allergies: ____________________________________

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8. Pease indicate if your child has any dietary restrictions: ____________________________________

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9. Please indicate if your child has any sleep requirements: ____________________________________

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10. Please indicate if your child has had any of the following communicable illnesses:

☐ Chicken pox ☐ Measles ☐ Pink eye ☐ Whooping cough

☐ Rubella ☐ Other (please specify) ____________________________________

For Office Use Only

Enrollment date: ______________ Start date: ______________ Visiting date: ______________

☐ Enrollment form complete ☐ Policy review complete ☐ Immunization record received

☐ Registration fee received Start date for subsidy: ________________

Withdrawal date: ______________ Reason for withdrawal: ________________________

Additional details: ____

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Revised on 12/09/2017