BROOKLYN EARLY LEARNING & CHILDCARE CENTRE MEDICAL HISTORY

Child's Name: _____ Health Card #: _____

Family Physician: _____ Expiry Date: _____

Physician's Phone: _____ Address: _____

Does your child have any known allergies? Yes _____ No _____

If yes, please specify: _____

Does your child have any special medical conditions or health concerns? Yes _____ No _____

If yes, please specify: _____

Is your child diagnosed, or do you suspect your child may have a developmental condition or delay?

Yes _____ No _____ If yes, please specify: _____

My child suffers from: Headaches___ Earaches___ Sore throat___ Stomach ache___ Colds___

Other _____

IMMUNIZATION RECORD

MUST be filled out PRIOR to starting

Required by Department of Community Services for Licensing

Please give dates M / D / Y

	2 mth	4 mth	6 mth	12 mth	18 mth	4-6 yr
Influenza*						
DTaP-IPV-Hib Diphtheria, tetanus, acellular pertussis (whooping cough), polio, and Haemophilus influenzae type b						
RV Rotavirus						
Pneumo Conj. Pneumococcal conjugate						
Men C Conj. Meningococcal group C conjugate						
MMRV measles, mumps, rubella & varicella						
Tdap-IPV Tetanus, diphtheria, acellular pertussis (whooping cough), and polio						