3461 Dutch Village Rd., Halifax, NS, B3N 2S7
Phone: (902) 457-3313
Website: www.thechildrensgarden.ca
Email: childrensgarden@eastlink.ca

CHILD HEALTH QUESTIONAIRE

To be completed by the parent/guardian and family physician

Name of Child:_____ Date Completed:___/___/____ *(mm/dd/yyyy)*

Date of Birth: ___/___/_____*(mm/dd/yyyy)* Male / Female

Provincial Health Card Number:_____ Expiry Date:___/___/____ *(mm/dd/yyyy)*

Physician and Clinic

Family Physician:_____ Phone:_____

Clinic:_____

Clinic Address:_____

Dentist and Clinic *(if applicable)*

Family Dentist:_____ Phone:_____

Clinic:_____

Clinic Address:_____

Health and Developmental History

Describe your child's general health:

_____

_____

_____

Are there any serious medical conditions? Yes/No If yes, please describe:

_____

_____

_____

If your child has a serious conditions and is taking any medication, what medication and what dosage:

_____

_____

Does your child have any allergies to food, medications or contact allergies? Yes/No
Are there any foods which you prefer your child not to have for reasons other than allergy? (for example, religious reasons) Yes/No **If yes please list:**

_____ Allergy / Preference

_____ Allergy / Preference

_____ Allergy / Preference

If your child has an allergy, is the allergy severe enough to require medications or emergency treatment: Yes/No
If yes, describe and detail any medications and emergency treatment required below.
If no, please describe the reaction(s) your child may have below:

_____

_____

_____

Is there anything else you would like us to know about your child's health?

_____

_____

_____

IMMUNIZATION RECORD-Please provide dates Day/Month/Year			
AGE DUE	**DATE GIVEN**	**VACCINE**	**GIVEN BY** *(doctor signature)*
2 months	___/___/____	DTaP-IPV-Hib	
2 months	___/___/____	Pneumococcal Conjugate	
4 months	___/___/____	DTaP-IPV-Hib	
4 months	___/___/____	Pneumococcal Conjugate	
6 months	___/___/____	DTaP-IPV-Hib	
12 months	___/___/____	MMRV	
12 months	___/___/____	Meningococcal C	
12 months	___/___/____	Pneumococcal Conjugate	
18 months	___/___/____	DTaP-IPV-Hib	
4-5years	___/___/____	DTaP-IPV	

I, _____, hereby certify that all of the information provided above is
(parent name)
true and correct to the best of my knowledge.

I, _____. Hereby certify that my child, _____,
(parent name)
Is free of communicable diseases.

I, _____, hereby certify that if I have not immunized my child against the above communicable diseases, I understand I may be asked to keep my child home if there is an outbreak of any of the above . I understand that this is for my child's and family's safety.

By signing below I understand that I have agreed to all of the above information.

_____ _____

Parent Signature Date