Georgina Nurse Practitioner-Led Clinic

Child Registration Form

SECTION 1: CHILDS INFORMATION

Current Date (MM/DD/YYYY):		
Name:		
Date of Birth (MM/DD/YYYY):		
Sex:	☐ Male ☐ Female	
Home Address:		
Phone:	Home: ( ) -	Cell: ( )
Emergency Contact:	Name:	Phone No:
Health Card Number:		Expiry date (MM/DD/YYYY):

Birth History for Patient:

Was the pregnancy full term? **Yes** or **No** Were there complications with the pregnancy or delivery? **Yes** or **No**

How much did your child weigh at birth? _____

Past Medical History: Has the child had any of the following conditions:

□ Abdominal problems □ Frequent Temper Tantrums □ Pneumonia □ Any serious injury □ Hay fever/Sinus Problems

□ School Problems □ Asthma □ Hearing Problems □ Seasonal Allergies □ Behavior Problems

□ Heart Problems □ Seizure □ Broken Bones □ Joint/Bone Problems □ Skills are behind other kids

□ Chronic Cough □ Kidney or Bladder infections □ Underweight □ Over Weight □ Constipation

□ Many ear infections □ Vision Problem □ Other _____

Any Allergies to Medications? **Yes** or **No** If yes, please list: _____
Any other allergies? **Yes** or **No** If yes, please list: _____

Any Medications/Supplements taken frequently? **Yes** or **No** If yes, please list:_____

Social History:

Child has how many siblings? _____

Current Grade in school/Preschool _____ School Attended: _____

Is your child in daycare/after school care? **Yes** or **No**

Who lives in the home? (list all family members as well as pets, friends etc)

_____

Vaccines:

Has your child received all recommended vaccinations for their age? **Yes** or **No**

If no, what is needed? _____