

Child Registration Form (under 14 years)

SECTION 1: CHILDS INFORMATION- ALL AREA'S MUST BE COMPLETED

Current Date (MM/DD/YYYY):	
Does the child reside in the Town of Georgina?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Legal Name:	
Date of Birth (MM/DD/YYYY):	
Health Card Number:	Expiry date (MM/DD/YYYY):
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address:	CITY POSTAL
Phone:	Home: () - Cell: () -
Name of Mother/Guardian:	Phone: ()
Name of Father/Guardian:	Phone: ()
Who is completing this form?	Name: Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify):
Who has been your child's previous provider? eg; Nurse Practitioner/Doctor	Name: _____ Address: _____ Phone number: (____)_____ - _____ Fax Number: (____)_____ - _____ (Should you choose to become a patient of the clinic you would be required to give up your provider elsewhere.)
Pharmacy:	Name: _____ City: _____

Birth History for Patient:

Was the pregnancy full term? ☐ Yes ☐ No

Were there complications with the pregnancy or delivery? ☐ Yes ☐ 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 ☐ Sinus Problems

☐ School Problems ☐ Asthma ☐ Hearing Problems ☐ 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 previous Surgeries? ☐ Yes ☐ No If yes, please list: _____

Any Allergies to Medications? ☐ Yes ☐ No If yes, please list: _____

Any other allergies? ☐ Yes ☐ No If yes, please list: _____

Any Medications/Supplements taken frequently? ☐ Yes ☐ 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 ☐ 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 ☐ No

If no, what is needed? _____