Georgina Nurse Practitioner-Led Clinic

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?	☐ Yes ☐ No
Child's Legal Name:	Preferred first name
Date of Birth (MM/DD/YYYY):	
Health Card Number:	Expiry date (MM/DD/YYYY):
Sex:	☐ Male ☐ Female Gender Identification(Optional):
Home Address:	
Phone:	Home: ( ) - Cell: ( ) -
Name of Mother/Guardian:	Phone: ( )
Name of Father/Guardian:	Phone: ( )
Who is completing this form?	Name: Relationship: ☐ Mother ☐ Father ☐ Guardian ☐ Friend ☐ 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? _____