CHILD'S HEALTH QUESTIONNAIRE

to be completed by the parent(s)

Name of Child: _____ **Date:** _____

Provincial Health Care Number: _____ **/Expiry Date:** _____

IN CASE OF EMERGENCY

Adult to contact if you cannot be reached

Name: _____ Relationship: _____

Telephone (work): _____ (home): _____

Physician and/or clinic

Name: _____

Address: _____

_____ Telephone: _____

IMMUNIZATION RECORD - Give Dates Y/M/D

	1st	2nd	3rd	4th	5th
DPTP					
HIB					
MMR					
TdP					
IB					
Other					

Dentist and/or clinic

Name: _____

Address: _____

_____ Telephone: _____