Creative Minds Early Childhood Center

Child Medical Form

Child's Name: _____
First Middle Last
Address: _____ Home Phone: _____
Date of birth: _____ Age: _____
Mother: _____ work phone: _____
Father: _____ work phone: _____

EMERGENCY CONTACTS
Name: _____ Phone: _____
Name: _____ Phone: _____
Child's doctor: _____ Phone: _____
Child's dentist: _____ Phone: _____
Child's health-care number: _____
Insurance Co.: _____ Policy#: _____
Hospital name: _____ Phone: _____

Additional information (e.g., food allergies, medication being taken, medication allergic to) ___
_____
_____

Medical: _____

Physical: _____

Developmental: _____

Emotional: _____

IMMUNIZATION RECORD
(Contact your local Ministry of Health for complete details before filling in this area.)

Immunizations are up to date: Yes_____ No_____

Has your child had:

Measles_____
German measles_____
Chicken pox_____
Mumps _____
Whooping cough _____
Other _____
_____

Does your child suffer from:

Headaches_____
Earaches_____
Stomachaches_____
Colds_____
Flu_____
Sore throat_____
Other_____

EMERGENCY MEDICAL CARE
I hereby grant permission for _____
to secure the necessary emergency medical treatment needed by my son/ daughter, _____
_____
in the event that I cannot be reached to otherwise authorize the same.

Date: _____

Parent signature:_____
Parent signature: _____