

1. Child Full Legal Name:

FAMILY INFORMATION

2. Primary Residence	and Househol	d Members:						
3. Secondary Residen	ce and Househ	old Members	:					
4. Mother's Place of Work					F	ull Time	Part Time	
Work Phone #:								
5. Father's Place of W	ork:					Full Time	Part Time	
Work Phone #:								
HEALTH INFORM	ATION							
6. Doctor's Name: Phone Nu					Number:			
7. Previous Doctor's Name: Phone Num					Number:			
8. Are your child/you □Yes □ No	th health recor	ds on file at A	Alberta Heal	lth Servic	ces Commu	inity Health	Centre?	
If No, where	are your child	l's health reco	rds located					
9. Are your child/you If No, please	uth immunizat state reason.	ions up to date	e? Yes	No				
10. Please give the na child has previously of			erapy (spee	ch, occup	oational the	erapy, physic	al therapy etc) that your	
a) Name:	Therapy:				Phone:			
☐ has previ	ously seen	\square is seeing	□is on w	aiting list	t □has a	applied to see		
b) Name:		Therapy:		Phone:				
☐ has previ	ously seen	☐ is seeing	□is on w	aiting list	⊟has a	applied to see		
11. Does your child/y	outh have any	allergies (foo	d, medicati	on, or otl	her)?	Yes	No If yes, please note	
Allergy: Triggers/Reaction:					,	Tre	eatment:	
			ers/Reaction:			Treatment:		
Exema:		Triggers/Reaction:				Treatment:		
Is medication needed		Yes - fill out					No	
12. Has your child/you			•		•	appiy:		
Mumps	Red Measles	German			Croup Diphtheria			
Chicken Pox	Scarlet Fever Bronchitis	Whooping Cough Tonsillitis			Polio			
Pneumonia Convulsions	Seizures	Ear Acl			Frequent C	olds		
Convuisions	Scizures	Lui 1101	103		-			
14. Sleep/Toileting/Eating	ng Problems?							
15. Problems at Birth?	Yes	No						
16. Have you ever had y	our child's hear	ing tested?	Yes	No				
Other medical info	rmation.							