Lunenburg Day Care Centre Health Questionnaire

26 Lincoln Street/P.O. Box 1551
Lunenburg, Nova Scotia
B0J 2C0

Child's Name: _____ Date of Birth: _____
Address: _____
Health Card #: _____ Expiry Date: _____

Adult to Contact in case of Emergency: _____
(Must be in the Lunenburg area) Relationship:_____
Emergency Contact #: home: _____ work: _____cell: _____

Physician's Name: _____ Telephone: _____
Address: _____
Dentist's Name: _____Telephone: _____
Address: _____

Medical Conditions: _____
_____
Allergies to medication, food, pets, bee stings, other: _____
_____
Is the allergy severe enough to require medication or medical treatment? Yes_____ No_____

Is your child's immunization up to date? _____If no, please list the reason why. _____
_____

Immunization Record:

2 months	DaPTP/Hib/Pneumococcal Conjugate	Date: _____
4 months	DaPTP/Hib/Pneumococcal Conjugate	Date: _____
6 months	DaPTP/Hib/Pneumococcal Conjugate	Date: _____
12 months	MMR/Meningococcal group C Conjugate/Varicella	Date: _____
18 months	DaPTP/Hib/Pneumococcal Conjugate	Date: _____
4-6 years	DaPTP/MMR	Date: _____

Any other vaccines _____

Background Information:

Siblings:
Name: _____Age: ____ Name: _____Age: ____
Name: _____Age: ____ Name: _____Age: ____
Others living in your home (names and relationship): _____
_____
Any pets? _____ Name of pets: _____

Does your child routinely take medications? _____
If yes, what is the medication and what is it for? _____
Has your child had any of the following: (check all that apply)
Measles ___ Chicken Pox ___ Whooping Cough ___ German Measles ___ Mumps ___
Eczema ___ Ear Infections ___ Asthma ___ Bronchitis ___ Pneumonia ___ Convulsions ___
Other _____

Does your child have any hearing or speech problems? _____
_____
Languages spoken at home _____
Name the foods your child likes, as well as those your child dislikes: _____
_____
_____
Has your child eaten peanut butter at home yet? _____
Are there any diet restrictions for your child? _____
Does your child nap? _____ For how long? _____
Can your child care for his/her own toileting needs? _____
Any problems with toileting? _____
Has your child had any previous experience with groups of children? _____
_____
Describe any particular fears your child has shown (e.g. to animals, loud noises, strangers, etc.) _____
Are there any particular observations which you have made about your child's behaviour which would be helpful to the day care staff? _____
_____
_____
Is there any other information about your child which you feel is important for us to be aware of? _____
_____

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date:_____