FIRM FOUNDATION
Before & After School Program

Medical Form

Child's Name: _____

Date of Birth (m/d/y) _____ Male / Female

Address: _____

_____

Previous Illnesses (Please check any that your child has had)

- □ German measles
- □ Measles
- □ Tuberculosis
- □ Asthma
- □ Chicken Pox
- □ Whooping cough
- □ Eczema
- □ Scarlet Fever
- □ Mumps
- □ Diphtheria
- □ Poliomyelitis
- □ Reaction to bites/stings
- □ Rheumatic Fever
- □ Other (please describe):

_____

_____

_____

Medical Conditions & History of Communicable Diseases:

Asthma: _____

Allergies: _____

Other: _____

Special Diet (i.e. Diabetic, Foods which are non-permissible due to Religious Reasons): _____

_____

Behaviour Issues: _____

_____

Communicable Diseases: _____

_____

Condition or Disorder(s) for which your child has received a medical diagnosis and is undergoing treatment or for which is currently being tested: _____

_____

In the event of an emergency where an ambulance is called and neither you nor your Emergency Contacts are able to arrive in time, you permit the staff to accompany your child by ambulance to the hospital.

We, _____ and _____, acknowledge that the information provided is accurate and agree to advise Firm Foundation of any changes to our child's medical health.

Parent Signature: _____ Date _____

Parent Signature_____ Date _____

OFFICE USE ONLY

Date of Admission: _____ Date of Withdrawal: _____