Little Bright Stars

Medical Information Form

Doctor's Name: ______________________________ Doctor's number: ______________

Doctor's Address: ____________________________ Postal code: ________________

1. Did your child had his/hers vision checked? ☐ Y ☐ N

2. Did your child had his/hers hearing checked? ☐ Y ☐ N

3. Did your child had his/hers dental check-up? ☐ Y ☐ N

4. Please indicate if your child has any health problems: ____

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5. Please indicate if your child is under treatment for any illness or injury, and if it will interfere with any activities:

____

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6. Please indicate if your child needs extra help/attention: ______________________________________

____

7. Please indicate if your child has any allergies: ____

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8. Please indicate if your child has any dietary restrictions: _____________________________________

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9. Please indicate if your child has any sleep requirements: _____________________________________

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10. Please indicate if your child has had any of the following communicable illnesses:

☐ Chicken pox ☐ Measles ☐ Pink eye ☐ Whooping cough

☐ Rubella ☐ Other (please specify) ______________________________________

For Office Use Only

Enrollment date: ______________ Start date: ______________ Visiting date: ______________

☐ Enrollment form complete ☐ Policy review complete ☐ Immunization record received

☐ Registration fee received Start date for subsidy: _________________

Withdrawal date: ______________ Reason for withdrawal: _________________________

Additional details: ____

Revised on 27/02/2017