"Stepping Stones" Medical Information

Family Doctor_____________________________ Phone_________________

Address____

____

Care card number____

Please list any concerns you have about your child's health (bleeding nose, asthma, convulsions etc)

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Has your child ever had an allergic reaction? Yes / No

If Yes, please give details below

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Has your child ever been stung by a bee or wasp? Yes / No

If Yes, how did he / she respond?

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Does your child have any on going medical conditions? Yes / No

If Yes, please give details

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Please note if your child has a medical condition that requires treatment, we require the medication to remain at the center

Is your child's immunization program up to date? Yes / No

(Please attach copy of immunization record)