



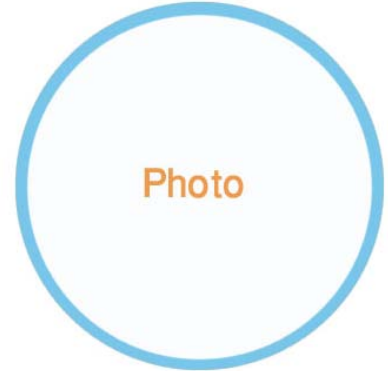
# Medical Questionnaire

## Child Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender:  Male   Female 



## Diseases

Has your child had any of the following conditions or diseases? (Please tick the columns)

	Yes	No
Measles		
German Measles		
Scarlet Fever		
Whooping Cough		
Mumps		
Chicken Pox		
Poliomyelitis		
Other?		

	Yes	No
Heart Disease		
Rheumatic Fever		
Kidney Disease		
Diabetes		
Infectious Hepatitis		
Convulsions		
Epilepsy		
Other?		

## Accidents or Operations

If your child has had any serious accidents or operations please explain:

## Allergies

Does your child have any allergies?  Yes  No

If yes, what is your child allergic to?

How does the allergy show itself?  Asthma  Hay Fever  Hives  Others

If others, please explain:

Notes:

Parent's Signature: .....

Date: .....