

CONFIDENTIAL MEDICAL HISTORY

Dear Parent. The following is a confidential medical history questionnaire that we ask you to complete. The information it provides is very important so we can be familiar with your child's health and assist us to provide the best care for your child.

Please mark the appropriate answer

Full Name _____ DOB / /

Family Medical Practitioner _____

Is your child taking any medication Yes No

List names _____

Has your child ever had a reaction or allergy to any medication Yes No

Describe _____

Has your child ever had a reaction or allergy to an antibiotic Yes No

Describe _____

Does your child have a known allergy to Latex, dressings or any metals Yes No

Describe _____

Does your child have any known food allergies Yes No

Describe _____

Does your child have any known insect sting allergies Yes No

Describe _____

Has your child been hospitalised for surgery or emergency care Yes No

List date and describe _____

Has your child ever had a reaction or problem with an anaesthetic Yes No

Describe _____

Does your child have any learning, behavioural or communication disorders Yes No

Describe _____

THIS FORM WILL BE DESTROYED IMMEDIATELY AFTER STORAGE