TASID

CHILD'S HEALTH FORM

CHILD'S NAME: **GENDER:**

DATE OF BIRTH:

ADDRESS:

PARENT(S) AND/OR GUARDIAN(S):

KNOWN ALLERGIES:

NAME OF CHILD'S MEDICATION (IF ANY):

MEDICATION DOSE: **FREQUENCY:**

MEDICAL CONCERNS:

HAS THE CHILD EVER BEEN TREATED BY ANY TYPE OF MEDICAL SPECIALIST?
(if yes, please provide details here)

MEDICAL HISTORY:

ASTHMA:

DIABETES MELLITUS:

SEIZURE DISORDER:

OTHER:

IMMUNIZATIONS RECORDS
(please attach a copy of your child's records to this form)

EXEMPTIONS If a child cannot or should not receive a particular immunization, please tick one of the following reasons in the "Doctor or Clinic" column

- [ ] HAS HAD DISEASE *(please attach physician's note)*.
For Rubella only a serologic test is a valid exemption.
- [ ] ALLERGIC TO *(specify allergen and please attach physician's note).*
- [ ] PARENT'S WILL NOT CONSENT *(please attach parent consent form).*
- [ ] OTHER reason *(please specify it).*

Signature: Date: