

# CENTRE GREENE AFTER-SCHOOL MEDICAL FORM

CHILD'S NAME: \_\_\_\_\_  
MEDICARE NUMBER: \_\_\_\_\_  
EXPIRY DATE: \_\_\_\_\_

CHILD'S DOCTOR: \_\_\_\_\_  
DOCTOR'S PHONE NUMBER: \_\_\_\_\_

HOSPITAL PREFERENCE: \_\_\_\_\_

1. Does your child have any food allergies? \_\_\_\_\_

2. Other allergies: \_\_\_\_\_

Has your child ever experienced any of the following?

Asthma	YES	<input type="checkbox"/>	Problems with eyesight	YES	<input type="checkbox"/>
Head Injury		<input type="checkbox"/>	Problems with hearing		<input type="checkbox"/>
Epilepsy		<input type="checkbox"/>	Heart problems		<input type="checkbox"/>

Other (please specify): \_\_\_\_\_

4. Any chronic health problems (ex. diabetes, bronchitis, etc.)?  
Please specify: \_\_\_\_\_

5. Does your child take medication regularly? \_\_\_\_\_

6. Does your child have behavioral difficulties? \_\_\_\_\_

7. Does your child have learning difficulties? \_\_\_\_\_

8. Additional comments: \_\_\_\_\_

I authorize the Centre Greene Afterschool Programme to take necessary action in relation to the health of my child in the case of an emergency.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_