

**Dartmouth Day Care Centre**  
**Child's Health Questionnaire**

Child's Name: \_\_\_\_\_

Health Card #: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

Immunization Record (please give specific dates (y/m/d))

	<u>2mths</u>	<u>4mths</u>	<u>6mths</u>	<u>18mths</u>
<b>DaPTP&amp; HIB</b> (Haemophilus Influenza conjugate Vaccine)				
<b>DaPtP</b> (Diphtheria, acelluar, Pertussis, Tetanus, & Polio vaccine)		<u>4-6 years</u>		
<b>MMR</b> (Measles, Mumps, Rubella vaccine)		<u>1 year</u>	<u>4-6 years</u>	

<b>Varicella</b> (Chicken pox)	<u>1 year</u> (Or 4-5 years prior to school I entry)
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 Dartmouth NS B3H 1A1  
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 Fax: 902-434-7324

33 Crichton Avenue  
 Dartmouth NS B2Y 1P1  
 Tel: 902-469-3739  
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Please Note the following:

- ❖ *DaPTP and Hib are combined in a single injection at 2, 4, 6, and 18 months of age. Varicella is now recommended at 12 months of age.*
- ❖ *Please inform director of new immunization dates as they occur.*
- ❖ *If you are choosing not to immunize your child/children, please contact the director to fill in a waiver form. A doctor's note will be required.*

Please provide the name of your child's current physician and dentist.

Name of Doctor: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

### General Information:

Please list the other children in the household:

1. \_\_\_\_\_ AGE: \_\_\_\_\_

2. \_\_\_\_\_ AGE: \_\_\_\_\_

3. \_\_\_\_\_ AGE: \_\_\_\_\_

Languages spoken at home: \_\_\_\_\_

Has your child been care for by others (Relatives, Neighbours) (Yes) (No)

If your child has had a group play experience, please describe how often your child was attending and what that experience was like:

HEALTH AND DEVELOPMENTAL HISTORY:

(1) Describe any difficulties or serious illnesses that we need to be aware:

(2) Describe your child's general health (i.e. colds, infections,)

(3) Are there presently any serious medical problems?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES please describe the medical problem:

If your child is taking any medication, what medication is it?

(4) Has your child been to a dentist?

(5) Does your child have any dental problems? Please describe

(6) Describe how your child communicates:

(7) How would you describe your child's emotional, physical, social and cognitive growth to this point?

### **Diet and Allergies:**

(1) Describe your child's diet (include types of food and fluids she or he is now taking):

PLEASE LIST ALL ALLERGIES (food and medication)

(2) Describe how your child reacts and list the symptoms if known:

(3) Has your child eaten peanut butter at home? (Yes)/(No)

(4) Diet restrictions: (cultural, religious) ( Please List Foods)

(5) Describe any particular concerns you have about your child's diet:

(6) How frequently does your child have a Bowel Movement?

(7) How far has your child progressed in toilet training?

**Behavioural Patterns and Habits:**

(1) Describe your child's behaviour and habits (i.e. Temperament, energy level)

(2) Describe an ordinary day in your child's life:

(3) Describe your child's particular attachments (toy, blanket, pet)

Any Habits?

(4) Describe any particular fears your child has shown (i.e. animals, loud noises, strangers)

(5) Describe how your child reacts to stressful situations (i.e. cries/ temper)

(6) How does your child react to new situations?

We would appreciate your views on guiding your child's behaviour and setting limits for behaviour management:

Is there anything else that you would like to tell us about your child to help us provide the best care possible?

**Parents/Guardian Printed Name:**

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**Signature:**

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**Date:** \_\_\_\_\_