

First Name: _____ Last Name: _____

HEALTH HISTORY:

DATE OF BIRTH: _____ BOY GIRL

HEALTH INSURANCE COMPANY AND POLICY #: _____

PERSON IN CHARGE OF THE CHILD:

LAST NAME _____ FIRST NAME _____

ADDRESS (where you will be while your child is at camp)

TELEPHONE NUMBER, Home _____ Cell: _____ Office: _____

THIS FORM ALLOWS US TO HAVE USEFUL INFORMATION DURING YOUR CHILD'S STAY; IT WILL AVOID ASKING YOUR DOCTOR FOR YOUR CHILD'S HEALTH RECORDS.

VACCINATIONS (refer to health records or child's vaccination certificate).

| REQUIRED VACCINES | Yes | No | DATES of BOOSTER SHOTS | RECOMMENDED VACCINES | DATES |
|-------------------|-----|----|------------------------|-----------------------|-------|
| Diphtheria | | | | Hepatitis B | |
| Tetanus | | | | Rubella-Mumps-Measles | |
| Poliomyelitis | | | | Whooping cough | |
| OR DT polio | | | | Others (specify) | |
| OR Tétracoq | | | | | |
| BCG | | | | | |

IF YOUR CHILD DOES NOT HAVE THE REQUIRED VACCINES, PLEASE ENCLOSE A MEDICAL CERTIFICATE OF CONTRA-INDICATION.

ATTENTION: THE ANTI-TETANIC VACCINE PRESENTS NO CONTRA-INDICATION

MEDICAL INFORMATION CONCERNING YOUR CHILD

Will your child be under any medical treatment during the school year? Yes No

If yes, please specify:

HEALTH HISTORY:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING ILLNESSES?

| | | | | |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| RUBELLA Yes <input type="checkbox"/> No <input type="checkbox"/> | CHICKEN POX Yes <input type="checkbox"/> No <input type="checkbox"/> | PHARYNGITIS Yes <input type="checkbox"/> No <input type="checkbox"/> | Acute Rheumatoid Arthritis Yes <input type="checkbox"/> No <input type="checkbox"/> | SCARLET FEVER Yes <input type="checkbox"/> No <input type="checkbox"/> |
| WHOOPING COUGH Yes <input type="checkbox"/> No <input type="checkbox"/> | EAR INFECTION (Otitis) Yes <input type="checkbox"/> No <input type="checkbox"/> | MEASLES Yes <input type="checkbox"/> No <input type="checkbox"/> | MUMPS Yes <input type="checkbox"/> No <input type="checkbox"/> | |

ALLERGIES: Asthma yes no Medicinal yes no
 Food yes no Others _____

Specify the cause of allergy and the course of action to be taken (please indicate if auto medication)

INDICATE BELOW:
 HEALTH PROBLEMS (ILLNESS, ACCIDENT, CONVULSIVE FIT/ATTACK, HOSPITALIZATION, OPERATION, REHABILITATION) SPECIFYING DATES AND PRECAUTIONS TO BE TAKEN.

USEFUL INFORMATION
 DOES YOUR CHILD WEAR CONTACT LENS, GLASSES, HEARING AIDS, FALSE TEETH, ETC... Please specify.

Name and telephone of family doctor/*médecin traitant* (optional):

I, the undersigned _____, legally responsible for the child, hereby certify that the information on this form is correct and authorize the person in charge of the Preschool to take, if needed, any measures (medical treatment, hospitalization, surgical operation) made necessary by the child's condition.

Signature: _____ Date: _____

Prénom : _____ Nom: _____

PERMISSIONS

Permission to Photograph and Film

I _____ give permission for Ecole Koenig
< parent's name >

to photograph my child(ren), _____
< name(s) of child(ren) >

for the following purposes :
scrapbooks, bulletin boards, website, and promotional materials, shown to current and prospective clients, as well as to be given to current families.

** Only first names will be used on any document printed or presented online*

I recognize that this is a binding legal agreement. To revoke this agreement, I must send a registered letter to the Preschool for Music & Art.

Date : _____ Mother's Signature : _____

Date : _____ Father's Signature : _____