MEDICAL INFORMATION AND HISTORY

NAME	**ADDRESS**	**PHONE**
Pediatrician: ____________________	____________________	______________
Neurologist: ____________________	____________________	______________
Orthopedist: ____________________	____________________	______________
Surgeon: ____________________	____________________	______________
GI: ____________________	____________________	______________
Other: ____________________	____________________	______________

DOES YOUR CHILD HAVE ANY ALLERGIES: ☐ **YES** ☐ **NO**

IF YES, PLEASE LIST (INCLUDE FOOD AND DRUG ALLERGY): ______________________________

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DOES YOUR CHILD HAVE A HISTORY OF SEIZURES? ☐ **YES** ☐ **NO**

PLEASE LIST PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES:

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PLEASE GIVE BRIEF SUMMARY OF YOUR CHILD'S PERTINENT MEDICAL HISTORY:

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PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING (INCLUDE NAME, DOSAGE AND FREQUENCY):

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