Centre Greene After School Program Medical Form

Medical Information	
Child's Name	
Medicare Number	Expiry Date
Child's Doctor	
Doctor's Phone #	
Hospital Preference	

Allergies	
Please list any **Food Allergies**	
Please list any **Other Allergies**	

Medical History	
Please list any **chronic health problems**	
Please list any **medications**	
Please list any **behavioural difficulties**	
Please list any **learning difficulties**	
Please include any additional information	

Has your child ever experienced any of the following:

☐ Asthma ☐ Head Injury ☐ Problems with Eyesight ☐ Problems with Hearing

☐ Epilepsy ☐ Heart Problems ☐ Other (please specify) ____________________

I authorize the Centre Greene After School Program to take necessary action in relation to the health of my child in the case of an emergency.

Signature: ____________________ Date: ____________________