

EKSA O' KON: A CHILDCARE CENTRE
TYENDINAGA MOIIAWK TERRITORY
613-967-4401 FAX 613-967-3789

DATE: _____ HEALTH CARD# _____
CHILDS NAME _____
DATE OF BIRTH _____
PHYSICIAN'S NAME _____
PHYSICIAN'S ADDRESS _____
PHYSICIAN'S PHONE# _____

Does the examination reveal any abnormality in:

Describe fully abnormalities

HEIGHT:

WEIGHT

GENERAL APPEARANCE, POSTURE, GAIT:

SPEECH:

SKIN:

EYES: EXTERNAL AND CANALS
TYMPANIC MEMBRANES

NOSE, MOUTH, PHARYNX

TEETH

HEART

LUNGS

ABDOMEN (Includes hernias)

GENITALIS

BONES, JOINTS, MUSCLES

NEUROLOGICAL EXAMINATION

OTHER

SUMMARY OF FINDINGS, TREATMENTS AND RECOMMENDATIONS RECORD
OF PAST DISEASES

Scarlet Fever Chicken Pox Measles Red Measles German
Whooping Cough Frequent Colds_ Stomach Aches Rheumatic

IMMUNIZATION (DATE/MO/YR) DATE REC'D BEFORE SCHOOL

Diphtheria }

Tetanus }

Whooping Cough }

Polio }

Small pox

Measles, Rubella, Mumps

Booster Shots

Allergies Drugs Food_ Animals Asthma Other

Treatment _____

Medical Alerts_ _____

Operations: Tonsils Other Reason _____

Dates of Operations

Further hospital operations

Possible time duration _____

Signature of Doctor