

ALLERGIES:

CHILD HEALTH RECORD

This card must accompany the child while in care.

Surname <u>CAIRNS</u>		Forename(s) <u>SHARON</u>	
Date of Birth <u>23-12-75</u>	Place of Birth		

BRIEF HISTORY OF CHILD

Current Medication <u>NONE</u>	Disabilities: <u>NONE</u>
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3 Infectious illnesses with dates

Infections

Measles _____ Mumps _____ Others _____
German Measles _____ Chicken Pox _____
Whooping Cough _____

Immunisation Record.

Booster

	1.	2.	3.	Booster
Polio Vaccination	1. _____	2. _____	3. _____	_____
Triple Antigen	1. _____	2. _____	3. _____	_____
Whooping Cough	1. _____	2. _____	3. _____	_____
Diphtheria/Tetanus	1. _____	2. _____		_____
Rubella	1. _____			_____
Measles	1. _____			_____
B.C.G.	1. _____			_____
Other (state)	_____	_____	_____	_____

Other conditions or operations with dates and hospitals (if attended)

Any relevant medical history

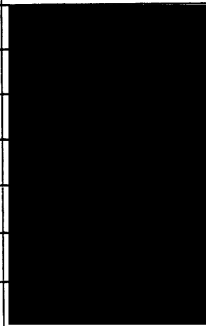
CHILD HEALTH RECORD

SHARON CAIRNS

[illegible]

SURNAME CAIRNS	FORENAMES SHARON	MAIN PRES	TON SHEET	KNOWN ALLERGIES 1	2
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ORAL AND OTHER NON PARENTERAL MEDICINES — REGULAR PRESCRIPTIONS

	DATE COMMENCED	MEDICINE (Block Letters)	DOSE	METHOD OF ADMINISTRATION	TIMES OF ADMINISTRATION								SIGNATURE	DATE OF DISCONTINUATION	INITIALS
					6	10	12	14	18	22	OTHER TIMES				
A	30-1-91	ANADIN EXTRA	2 TABLETS	ORALY					10	-	15	pm		30-1-91	
B	31/1/91	ANADIN EXTRA	2 TABLETS	ORALY					12	-	45	AM		31/1/91	
C	31/1/91	PENICILLAN	1 TABLET	ORALY					10	-	35	pm		31/1/91	
D	3/2/91	1 PENICILLAN	1 TABLET	ORALY					11	-	15	pm		3/2/91	
E	4/2/91	1 PENICILLAN	1 TABLET	ORALY					11	-	30	pm		4/2/91	
F	5/2/91	1 PENICILLAN	1 TABLET	ORALY					9	-	30	am		5/2/91	
G															
H															
I															
J															
K															
L															

PARENTERAL MEDICINES — REGULAR PRESCRIPTIONS

M															
N															
O															
P															
Q															
R															

ONCE ONLY PRESCRIPTIONS — ORAL and OTHER NON — PARENTERAL MEDICINES

ONCE ONLY PRESCRIPTIONS — PARENTERAL MEDICINES

DATE	MEDICINE	DOSE	METHOD OF ADMIN.	TIME OF ADMIN.	SIGNATURE	GIVEN BY (INITIALS)	TIME (IF DIFF)	DATE	MEDICINE	DOSE	METHOD OF ADMIN.	TIME OF ADMIN.	SIGNATURE	GIVEN BY (INITIALS)	TIME (IF DIFF)

CAIRNS SHARON Room 6

[illegible]

[illegible]

[illegible]

[illegible]

Medical Information at Application (RIC 2)

Child's Surname CAIRNS	
Forename(s) SHARON ELAINE	
D.O.B. 23.12.75	CP.No.

Previous Infections - indicate YES or NO or NOT KNOWN. If YES, give date.

Measles YES	Chicken-pox NO
German Measles NO	Scarlet Fever NO
Whooping Cough NO	Diphtheria NO.
Mumps NO	Other - Specify NO.
Dysentery NO.	

Completed Inoculations - indicate YES or No. If Yes, give date.

Smallpox YES	Polio YES.
Triple Antigen - diphtheria, whooping cough, tetanus. YES.	Measles
B.C.G. NO	Other - Specify (e.g. German Measles) NO.

Has the child had any operations? If so, where, when, and for what?

NO

Is a special diet required e.g. diabetic? If so please specify.

NO.

Has the child attended a Child Guidance Clinic? If so when and where?

NO.

Does the child have any particular behavioural difficulties?

NO.

PARENT'S DECLARATION

I declare that the information given on this form is correct.

Signature

Date

PLEASE COLLECT NATIONAL HEALTH CARD