Santa Barbara Botanic GARDEN

Medical Information

Child's Name _____ Date of Birth _____ M F Sex (circle)

Hospital/Clinic Preference _____

Physician's Name _____ Phone Number ( ) _____

Insurance Company _____ Policy Number _____

Does your child have any food, medication or environmental allergies? ☐ Yes ☐ No

If yes, please list: _____

Does your child have any medical conditions staff should be aware of (asthma, seizures, etc.)? ☐ Yes ☐ No

If yes, please list: _____

Does your child require any medication throughout the day or for medical conditions? ☐ Yes ☐ No

If yes, please list and explain: _____

Are your child's immunizations up-to-date on the following vaccines? ☐ Yes ☐ No

- Polio
- Diphtheria, Tetanus, and Pertussis (DTaP)
- Hepatitis B
- Haemophilus influenzae type B
- Measles, Mumps, and Rubella (MMR)
- Varicella (Chickenpox)

Date of child's last tetanus shot: _____

Are there any other medical conditions/considerations staff should be aware of?

_____

_____

_____

_____

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