ICA Medical Record

Date __________________

Name:	
Date & Place of Birth:	
Parent's Name & Address:	
In case of emergency, how can we reach you quickly? Telephone / email / fax / radio?	
What anti-malarial prophylactic drug do you prefer to have your child to take?	Please send a personal supply if other than: Daraprim, Chloroquine (Nivaquine), Paludrine, Mephaquine/Lariam, Doxycycline
Do you have a preferred treatment for malaria?	
Your child's blood type is:	

List any

1. Allergy your child has to: a. Medications b. Food c. Other	
2. Present physical problems or limitations	
3. Special medication your child is taking	
4. Dietary restrictions	
5. Medical / surgical history	

If your child had any of these diseases, please give dates:	**Date**		**Date**
Chicken Pox		Diphtheria	
Measles		Mumps	
Whooping Cough		Hepatitis	
Other		Other	
Give most recent dates of Immunizations:	**Date**		**Date**
Yellow Fever		DPT (Diphtheria, Pertussis, Tetanus) initial series	
Polio, Oral		DT (Diphtheria, Tetanus) booster	
Polio, Injectable		MMR (Measles, Mumps, Rubella) #1, #2	
BCG (anti-tuberculosis vaccine)		Meningitis	
Hepatitis A vaccine: #1, #2		Rabies	
Hepatitis B vaccine: #1, #2, #3		Typhoid	