ICA Medical Record

Name: _____ **Date** _____

Date of Birth: ____/____/____ (mm/dd/yyyy) Place of Birth: _____

Parent's Name & Address:	In case of emergency, how can we reach you quickly? Telephone / cell phone / email / 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

Allergies your child has to:	Present physical problems or limitations:
Medications	
Food	Special medication your child is taking:
Other	Dietary restrictions:
Medical / surgical history:	

If your child has had any of these diseases, please give dates:

Disease	Date	Disease	Date
Chicken Pox		Mumps	
Measles		Hepatitis	
Whooping Cough		Other	
Diphtheria			

Give *most recent* dates of these immunizations:

Immunization	Date
Meningitis	
Typhoid	
Yellow Fever	
BCG (anti-tuberculosis vaccine)	

Please give *all* dates of the following immunizations:

	Date		Date		Date	Polio Vaccine	
						Oral	Injection
Hepatitis A #1		DPT (Diptheria, Pertussis, Tetanus) #1		DT (Diptheria, Tetanus) booster #1			
#2		#2		#2			
Hepatitis B #1		#3		MMR (Measles, Mumps, Rubella) #1			
#2		#4		#2			
#3		#5		Measles			