Confidential Information Form - Child

Dětská ambulance
PEDIATRIC HEALTH CENTRE

Surname of Child		DOB or Insurance number	/ / Day – Month – Year
First Name of Child		Sex	
Mother's Surname And First Name		Mother's Nationality	
Father's Surname and First Name		Father's Nationality	
Mother's Phone		Father's Phone	
Mother's E-mail		Father's E-mail	
Home Address in the Czech Republic			
Contact Person in Case of Emergency		Home Phone	

Child's Medical Insurance Co.	

Affirmation

I confirm that I have been informed about my right at any time to request information about costs associated with my child's treatment at Dětská ambulance.

Parent's Signature ..... Date

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Dear Parent
In order to provide more efficient medical services, kindly provide us with the following information about your child:

Does your child suffer from any allergies, e.g. food, medications, food etc.?			
Yes	No	Type of Allergy	
Manifestation of Allergy			
Was the delivery on time?			
Yes	No	No. of days prior due date?	
Method of delivery?			
Vaginal		C-section	
Weight at birth		Height at birth	
Were there any complications prior or after delivery?			
Yes	No	Type of complications	
Does your child suffer from any birth defects?			
Yes	No	Type of defect	
Was/is your child breastfed?			
Yes	No	Length of nursing	
Was your child ever hospitalized?			
Yes	No	When?	
Reason for hospitalization			
Did your child ever have an accident?			
Yes	No	Type of accident	
Did your child ever undergo an operation?			
Yes	No	Type of operation	
Does your child suffer from chronic diseases?			
Yes	No	Type of chronic disease	
Is your child under the supervision of a physician?			
Yes	No	What physician?	
Does your child take medication long-term?			
Yes	No	Type of medication	
Is your child's vaccination up-to-date?			
Yes	No	Missing vaccination	
Vaccination administered according to which state?			