Pavilion Pediatrics at Green Spring Station, P.A.

Parent Questionnaire for Completion of Forms

Please complete this form along with the Parent portion of the child's Form.

Patient Name: _____ Date of Birth _____

1. List any medications the child is currently taking or indicate none.

Medication Name	Strength (mg/ml)	Dosing (How much how often)

2. List any medications to be administered at camp/school/sports/daycare or indicate none. If yes indicate strength, days and times each medication is to be administered.

Medication Name	Strength (mg/ml)	Dosing (How much how often)

3. List any medications allergies or indicate none.

4. List any food allergies or indicate none. If yes, does the patient require an epi-pen?

5. Does the child wear glasses or contact lenses?

6. Has your child ever had a concussion? If yes, please indicate the date and cause.

7. List all surgeries/hospitalizations, reason and date or indicate none.

8. List all medical problems.

9. Has your child received the COVID vaccine?

Form completed by: _____ Date: _____