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. Use reverse side if needed.

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.

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 ever been diagnosed with COVID-19? If so when (Please include dates MM/DD/YYYY)?

10. Has your child received the COVID vaccine? If yes, please add dates below:

COVID-19 VACCINE DATES			
Vaccine	**Product Name/Manufacturer**	**Date**	**Healthcare Professional or Clinic Site**
1st DOSE COVID-19		___/___/___ *mm / dd / yy*	
2nd DOSE COVID-19		___/___/___ *mm / dd / yy*	
3rd DOSE COVID-19		___/___/___ *mm / dd / yy*	

Form completed by: _____ Date: _____