

Name:

DOB:

Year:

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Name:

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QUICK GLANCE TREATMENTS

DATE	COMPLAINT	TREATMENT
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ILLNESS TYPE	First Aid	Acute	Chronic	RESPONSE	No Change	Better
Much Better						

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ILLNESS TYPE	First Aid	Acute	Chronic	RESPONSE	No Change	Better
Much Better						

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Name:

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Mother's Labor/Birth Notes:

Health Information:

Breastfed? Yes No If Breastfed, how long? _____ Self-weaned? Yes
 No

If bottle fed, formula type:

Reactions to formula:

Food introduction notes:

Food Sensitivities/Allergies (date observed):

Name:

DOB:

Year:

Medicines given regularly:

Allergies to medication:

Vitamin/mineral supplements regularly given (1-4 years old):

5-12 years:

13-18 years:
