

Childhood Illness & Immunizations

Childhood Illnesses: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Immunization	Date
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> MMR (<i>measles, mumps, rubella</i>)	
<input type="checkbox"/> Pneumococcal (<i>pneumonia</i>)	
<input type="checkbox"/> Varicella (<i>chickenpox</i>)	
<input type="checkbox"/> Hepatitis A	
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Meningococcal C (<i>meningitis</i>)	
<input type="checkbox"/> Influenza (<i>flu</i>)	

A copy of my child's immunization record is attached

Surgeries

Year	Surgery & Reason (<i>eg. G-tube insertion – unsafe to swallow liquids</i>)	Hospital

Hospitalizations

Year	Reason for Admission (<i>eg. pneumonia</i>)	Hospital

CURRENT HEALTH CONCERNS

Seizures

Does your child have seizures? Yes No

For each type of seizure complete a separate section below and check off all that apply.

Type of Seizure #1

- | | | |
|---|---|--|
| <input type="checkbox"/> Simple Partial (Focal) | <input type="checkbox"/> Generalized absence (Petit mal) | <input type="checkbox"/> Myoclonic |
| <input type="checkbox"/> Complex Partial (Psychomotor/temporal) | <input type="checkbox"/> Generalized tonic-clonic (Grand mal) | <input type="checkbox"/> Atonic (Drop) |

During the seizure your child is usually

<input type="checkbox"/> Asleep	<input type="checkbox"/> Blue	<input type="checkbox"/> Pale	<input type="checkbox"/> Flushed
<input type="checkbox"/> Awake	<input type="checkbox"/> Clammy	<input type="checkbox"/> Normal	<input type="checkbox"/> Other

First signs of the seizure are typically

<input type="checkbox"/> Unusual behaviour	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Cries out
<input type="checkbox"/> Pupils dilated	<input type="checkbox"/> Stare	<input type="checkbox"/> Eyes flutter
<input type="checkbox"/> Body movements	<input type="checkbox"/> Eyes roll	<input type="checkbox"/> Other:

Body movement during the seizure	<input type="checkbox"/> Sudden fall <input type="checkbox"/> Gradual fall	<input type="checkbox"/> Jerk/twitching <input type="checkbox"/> Rigidity	<input type="checkbox"/> Head turns to L/R <input type="checkbox"/> Limpness	<input type="checkbox"/> Arched back <input type="checkbox"/> Other
Body parts normally involved	<input type="checkbox"/> Left side <input type="checkbox"/> Right side	<input type="checkbox"/> Legs <input type="checkbox"/> Face	<input type="checkbox"/> Arms <input type="checkbox"/> Entire body	<input type="checkbox"/> Other
Level of consciousness during seizure	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Awake but not responsive	<input type="checkbox"/> Able to respond	<input type="checkbox"/> Other
Breathing during seizure	<input type="checkbox"/> Normal	<input type="checkbox"/> Shallow & rapid	<input type="checkbox"/> Deep & noisy	<input type="checkbox"/> Respiratory arrest
Post seizure state	<input type="checkbox"/> Confused <input type="checkbox"/> Dizzy	<input type="checkbox"/> Irritable <input type="checkbox"/> Normal/alert	<input type="checkbox"/> Sleepy	<input type="checkbox"/> Other
Other	<input type="checkbox"/> Incontinent - urine <input type="checkbox"/> Incontinent – stool	<input type="checkbox"/> Injuries <input type="checkbox"/> Other:		

Type of Seizure #2				
<input type="checkbox"/> Simple Partial (Focal)	<input type="checkbox"/> Generalized absence (Petit mal)	<input type="checkbox"/> Myoclonic		
<input type="checkbox"/> Complex Partial (Psychomotor/temporal)	<input type="checkbox"/> Generalized tonic-clonic (Grand mal)	<input type="checkbox"/> Atonic (Drop)		
During the seizure your child is usually	<input type="checkbox"/> Asleep <input type="checkbox"/> Awake	<input type="checkbox"/> Blue <input type="checkbox"/> Clammy	<input type="checkbox"/> Pale <input type="checkbox"/> Normal	<input type="checkbox"/> Flushed <input type="checkbox"/> Other
First signs of the seizure are typically	<input type="checkbox"/> Unusual behaviour <input type="checkbox"/> Pupils dilated <input type="checkbox"/> Body movements	<input type="checkbox"/> Stiffness <input type="checkbox"/> Stare <input type="checkbox"/> Eyes roll	<input type="checkbox"/> Cries out <input type="checkbox"/> Eyes flutter <input type="checkbox"/> Other:	
Body movement during the seizure	<input type="checkbox"/> Sudden fall <input type="checkbox"/> Gradual fall	<input type="checkbox"/> Jerk/twitching <input type="checkbox"/> Rigidity	<input type="checkbox"/> Head turns to L/R <input type="checkbox"/> Limpness	<input type="checkbox"/> Arched back <input type="checkbox"/> Other
Body parts normally involved	<input type="checkbox"/> Left side <input type="checkbox"/> Right side	<input type="checkbox"/> Legs <input type="checkbox"/> Face	<input type="checkbox"/> Arms <input type="checkbox"/> Entire body	<input type="checkbox"/> Other
Level of consciousness during seizure	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Awake but not responsive	<input type="checkbox"/> Able to respond	<input type="checkbox"/> Other
Breathing during seizure	<input type="checkbox"/> Normal	<input type="checkbox"/> Shallow & rapid	<input type="checkbox"/> Deep & noisy	<input type="checkbox"/> Respiratory arrest
Post seizure state	<input type="checkbox"/> Confused <input type="checkbox"/> Dizzy	<input type="checkbox"/> Irritable <input type="checkbox"/> Normal/alert	<input type="checkbox"/> Sleepy	<input type="checkbox"/> Other
Other	<input type="checkbox"/> Incontinent - urine <input type="checkbox"/> Incontinent – stool	<input type="checkbox"/> Injuries <input type="checkbox"/> Other:		

Type of Seizure #3				
<input type="checkbox"/> Simple Partial (Focal)	<input type="checkbox"/> Generalized absence (Petit mal)	<input type="checkbox"/> Myoclonic		
<input type="checkbox"/> Complex Partial (Psychomotor/temporal)	<input type="checkbox"/> Generalized tonic-clonic (Grand mal)	<input type="checkbox"/> Atonic (Drop)		
During the seizure your child is usually	<input type="checkbox"/> Asleep <input type="checkbox"/> Awake	<input type="checkbox"/> Blue <input type="checkbox"/> Clammy	<input type="checkbox"/> Pale <input type="checkbox"/> Normal	<input type="checkbox"/> Flushed <input type="checkbox"/> Other
First signs of the seizure are typically	<input type="checkbox"/> Unusual behaviour <input type="checkbox"/> Pupils dilated <input type="checkbox"/> Body movements	<input type="checkbox"/> Stiffness <input type="checkbox"/> Stare <input type="checkbox"/> Eyes roll	<input type="checkbox"/> Cries out <input type="checkbox"/> Eyes flutter <input type="checkbox"/> Other:	

Additional Information

PAIN				
Does your child experience pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Does your child experience acute pain or chronic pain, or both?	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic		
What are the most common causes of your child's pain?	<input type="checkbox"/> Headache	<input type="checkbox"/> Muscle stiffness	<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Joint stiffness
	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Other	<input type="checkbox"/> Other
How does your child express pain? <i>(Please check off all that apply)</i>				
Communication	<input type="checkbox"/> Verbally	<input type="checkbox"/> Sign language	<input type="checkbox"/> Other:	
Facial expression	<input type="checkbox"/> Squinting eyes	<input type="checkbox"/> Grinds teeth	<input type="checkbox"/> Distorted face	<input type="checkbox"/> Frowning
	<input type="checkbox"/> Thrusts tongue	<input type="checkbox"/> Furrows brow	<input type="checkbox"/> Other:	
Leg or general body movements	<input type="checkbox"/> Tense	<input type="checkbox"/> Gesture to part of body that hurts	<input type="checkbox"/> Other	
Activity or social interactions	<input type="checkbox"/> Not cooperative	<input type="checkbox"/> Irritable	<input type="checkbox"/> Unhappy	<input type="checkbox"/> Cranky
	<input type="checkbox"/> Less active, quiet	<input type="checkbox"/> More active, fidgety	<input type="checkbox"/> Other:	
Cry or vocalization	<input type="checkbox"/> Moaning	<input type="checkbox"/> Crying	<input type="checkbox"/> Yelling	<input type="checkbox"/> Whimpering
	<input type="checkbox"/> Other:			
Consolability	<input type="checkbox"/> Less interaction		<input type="checkbox"/> Difficult to distract or satisfy	
	<input type="checkbox"/> Seeks comfort		<input type="checkbox"/> Other:	
Other changes	<input type="checkbox"/> Tears	<input type="checkbox"/> Holds breath	<input type="checkbox"/> Gasping	
	<input type="checkbox"/> Sweating	<input type="checkbox"/> Other:		
Other measures used to relieve your child's pain?	<input type="checkbox"/> Distraction	<input type="checkbox"/> Warmth	<input type="checkbox"/> Cold	<input type="checkbox"/> Relaxation
	<input type="checkbox"/> Other:			



OTTAWA ROTARY HOME – PAIN SCALE

Please complete the following numeric pain scale using the terms on the previous page to identify your child’s expression of pain at each level. Zero indicates your child’s behaviour/mood when they are in no pain and ten indicates your child’s behaviour/mood when they are in the worst pain ever. Above each number on the pain scale indicate your child’s expression of pain and below that number indicate how you would attempt to relieve your child’s pain at that level.

Expression of Pain											
Pain Score	0	1	2	3	4	5	6	7	8	9	10
Management of Pain											

I/We certify that the above information is accurate and complete.

(Signature of Parent or Guardian)

(Date)

(Signature of Parent or Guardian)

(Date)

For staff use.

Reviewed By:

Date:

Questions and points for clarification by parents.