**CHILD’S NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAY’S DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENTS’ NAMES/CONTACT #S: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

==================================================================================================

**Primary Care Provider (Name/Clinic):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Can we send a letter back to your child’s primary provider?** ☐ **YES** ☐ **NO**

**What are your primary goals for this visit/questions you have for your child’s doctor?**

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE CHECK THE SYMPTOMS YOUR CHILD IS CURRENTLY/VERY RECENTLY EXPERIENCING:**

**GENERAL: EYES: EARS/NOSE/SINUSES/THROAT:**

☐ Fever ☐ Itchy ☐ Stuffy nose ☐ Nosebleeds

☐ Watery ☐ Runny nose ☐ Snoring

☐ Red ☐ Sneezing

☐ Puffy ☐ Itchy nose

**LUNGS: HEART/BLOOD VESSELS: GI TRACT: SKIN:**

☐ Cough ☐ Color changes of skin ☐ Stomach pain ☐ Eczema

☐ Shortness of breath ☐ Irregular heartbeat ☐ Diarrhea ☐ Hives

☐ Wheezing ☐ Swelling in hands/feet ☐ Difficulty swallowing ☐ Itching

☐ Weight loss ☐ Swelling

**MUSCLES/BONES: BLOOD: NERVOUS SYSTEM:**

☐ Joint pain ☐ Swollen glands/nodes ☐ Pain

☐ Joint redness

☐ Joint swelling

**LOCAL PHARMACY: MAIL-ORDER PHARMACY:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cross-streets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have forms that you need completed by your child’s doctor? ☐ YES ☐ NO