SOMERSET HEALTH & WELLNESS CENTRE

190 Somerset St. West, Suite 210
Ottawa, ON K2P 0J4
Phone: 613-656-9629
Email: info@ottawanaturopathic.ca

Confidential Pediatric Intake *please print*

Welcome to the naturopathic clinic at The Somerset Health & Wellness Centre. Our philosophy of health care is to seek to understand all the factors that may be affecting your child's health. Please complete this form as thoroughly as possible, as your child's responses will assist your child's Naturopathic Doctor in making appropriate recommendations to support your child's return to optimal health. **Please bring all of the completed forms in this package with you to your child's first visit.**

Child's Name: _____ Today's date: _____

Date of Birth: _____/_____/ _____ Age: _____ Gender: _____

Month Day Year

Mother's Name: _____ Mother's Occupation: _____

Father's Name: _____ Father's Occupation: _____

Relationship Status: ☐single ☐married ☐divorced ☐separated ☐widowed ☐common-law ☐partner ☐other _____

If separated, child lives with: ☐mother ☐father ☐other _____

CONTACT INFORMATION **Please inform us if your child's information changes**

Address: _____

City: _____Province: _____ Postal Code: _____

Phone (H): _____

MOTHER: (Bus.): _____ (Cell): _____

E-mail: _____ Preferred number to call: ☐H ☐B ☐C

FATHER: (Bus.): _____ (Cell): _____

E-mail: _____ Preferred number to call: ☐H ☐B ☐C

Emergency Contact

Name: _____ Relationship: _____

Phone (H): _____ (Bus.): _____ (Cell): _____

How did you hear about our clinic? _____

HEALTHCARE PROVIDERS:

Primary Health Care Physician: _____ Phone: _____

When was your child's last physical exam? _____

Is your child currently under the care of a specialist? ☐Yes ☐No

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Is your child currently under the care of alternative health care providers? ☐Yes ☐No

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

CONTEXT OF CARE

Why did you choose to come to this clinic?

What 3 expectations do you have from THIS VISIT to our clinic?

What LONG TERM expectations do you have from working with our clinic?

What is your present level of commitment to address any underlying causes of your child's symptoms that relate to your lifestyle? (Please rate from 1 to 10, 10 being 100 % committed).

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your child's health? (Please list):

What behaviors or lifestyle habits do you currently engage in regularly that you believe are not supportive for your child's optimal health? (Please list):

HEALTH CONCERNS

Please list your child's health concerns, in order of greatest importance.

1. _____ 5_____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Others: _____

_____

Are there any traumatic events (surgeries, drug reactions, life trauma etc.) that you can identify as having caused or clearly aggravated your child's health problems?

_____

_____

VITAMINS AND SUPPLEMENTS

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies your child is taking

Supplement (include the brand)	Total daily dose	Reason for Use	Duration of Use

PRESCRIPTION MEDICATIONS

Please list all current medications and indicate the total dosage taken in one day.

Current Medications	Total daily dose	Reason for Use	Duration of Use

Please list any medications used in the past 12 months, but have now discontinued.

Medications In the Past 12 Months	Total daily dose	Reason for Use	Duration of Use

Are there any medications that your child has used, which you have not already mentioned?

_____

Number of times on antibiotics: _____

MEDICAL HISTORY

How would you describe your child's general health? ☐Excellent ☐Fair ☐Poor ☐Very Poor

Which illnesses has your child had?

☐ Asthma
☐ Rheumatic Fever
☐ Rubella (German Measles)
☐ Chicken Pox
☐ Scarlet Fever
☐ Whooping Cough
☐ Mumps
☐ Roseola
☐ Measles
☐ Polio
☐ Other:_____

Which vaccinations has your child had?

☐ DPT (diphtheria, tetanus, pertussis)
☐ HBV (hepatitis B)
☐ Hepatitis A
☐ Hib (Haemophilus influenza b)
☐ Influenza (flu shot)
☐ Meningococcal
☐ MMR (measles, mumps, rubella)
☐ Polio
☐ Smallpox
☐ Tetanus
☐ Typhus
☐ VZV (chicken pox)
☐ Other: _____

Adverse Reactions

Please describe any adverse reactions, allergies, or sensitivities your child has experienced with prescription or over-the-counter medications, recreational drugs, vaccinations (childhood, travel, flu, hepatitis), or natural medicines (herbs, vitamins, minerals,homeopathics)

Name of drug, vaccine or natural medicine	Describe the reaction

Please check the appropriate boxes for conditions your child suffers from currently (**C**) or in the past (**P**))

Condition	C	P	Condition	C	P	Condition	C	P	Condition	C	P
□Acne, Boils, Impetigo			□Sinusitis			□Diabetes			□Epilepsy		
□Shingles			□Allergies (Environmental)			□Hypoglycemia			□Meningitis		
□Eczema			□Hay Fever			□Eye Problems			□Bleeding problems		
□Keloids			□Bronchitis			□Kidney Problems			□Uterine Prolapse		
□Psoriasis			□Pneumonia, Pleurisy			□Cushing's Disease			□Vaginitis (recurrent)		
□Warts			□Asthma			□Addison's Disease			□Dizziness		
□Herpes (cold sores)			□Tuberculosis			□Thyroid: overactive			□Numbness		
□Urticaria			□Malnutrition			□Thyroid: underactive			□Hepatitis		
□Autism			□Obesity			□Eating Disorder			□Pancreatic Disease		
□Candida (yeast)			□Rickets			□Fainting			□Liver Disease		
□Irritable Bowel Syndrome			□Osteoporosis			□Heart Problems			□Bladder Problems		
□Colitis (inflamed bowel)			□Wilson's Disease			□Palpitation			□Parasites/Worms		
□Diverticulitis			□Chronic Fatigue Syndrome			□Circulation Problems			□Hiatal Hernia		
□Constipation			□Environmental Illness			□Anemia			□Appendicitis		
□Food Poisoning			□Human Papillovirus (HPV)			□Lupus			□Juvenile Rheumatoid Arthiritis		
□Diarrhea			□Chlamydia			□Strep Throat			□Other: (specify)		
□Mononucleosis			□Syphilis			□Backpain/Sciaticia					
□Jaundice			□HIV								

Past Surgeries and Tests (*Please check all that apply)*

Surgeries	Year
□Abdominal/Gastrointestinal	
□Appendectomy (Appendix removal)	
□Brain	
□Cancer (type?)	
□Gallbladder	
□Heart	
□Hernia	
□Sinuses	
□Tonsillectomy (tonsils)	
□Tubes in ears – 1st set	
□Tubes in ears – 2nd set	
□Other (specify):	

Tests	Year
□Chest x-ray	
□Colon x-ray	
□Abdominal x-ray	
□Kidney x-ray	
□Echocardiogram	
□Electrocardiogram (ECG or EKG)	
□Mammogram	
□Colonoscopy	
□Sigmoidoscopy	
□Angiogram	
□TB test	
□CT scan	
□MRI	
□Ultrasound	
□Blood tests (specify if possible)	
□Other (specify):	

Please list any hospitalizations and the year in which they occurred: _____
_____
_____

Please list any major injuries or traumas your child have suffered and indicate the year they occurred:
_____
_____
_____

Approximately how many times each year does your child get colds or the flu? _____

PRENATAL HISTORY

Parents health at conception (G = good, P = poor) Mother: _____ Father: _____
Was this child conceived naturally? □Yes □No

Any fertility interventions? □Yes □No

Has this child conceived naturally? □Yes □No

Any illness or difficulties during pregnancy? (circle)

Nausea • Diabetes • Hypertension • Thyroid problems • Emotional trauma • Vomiting •

Bleeding • Illness • Physical trauma • Other _____

List any drugs, alcohol, cigarette smoking or medications taken during pregnancy:

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____

List any vitamins or other supplements taken during pregnancy:

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____

Mother's age at birth: _____ Father's age at conception _____

Mother's pregnancy weight gain _____lbs

BIRTH HISTORY

How long was the pregnancy? (circle) full term • late • premature # of weeks ___

Was the labor *spontaneous* or *induced*? (circle)

Duration of labor: _____ hrs

Difficulties or complications: _____

_____

Was delivery by *C-section* or *vaginal birth*? (circle)

Hospital or home birth? (circle)

Birth weight? _____ Birth length: _____ APGAR Scores: 1 min _____ 5 min _____

Interventions: (circle) epidural • episiotomy • forceps • suction
Complications: _____
_____

NEONATAL HISTORY

Any difficulties or complications soon after birth?

□ Jaundice □ Poor feeding □ Birth defects □ Colic
□ Respiratory distress □ Anemia □ Rashes □ Other
□ Convulsions □ Infections

Age began: sitting _____ crawling _____ walking _____ talking _____1st tooth _____

Any problems with the child's teeth? _____

How would you characterize your child's development? (circle)

Physical : □slow □average □fast

Mental: □slow □average □fast

Has child started puberty? □Y □ N if yes, when? _____

NUTRITION

Breast fed – how long? _____ Formula fed – describe type:_____ When started: _____
Age of introduction of solids: _____

What were the first foods introduced?
1. _____ 5._____
2. _____ 6. _____
3. _____ 7. _____

Are there any food groups excluded from your child's diet? Why?
_____

FAMILY MEDICAL HISTORY

Is your child adopted? □No □Yes

Please indicate which of your child's blood relatives (mother, father, maternal/paternal grandparents, sibilings, aunts, uncles) has encountered any of the following health concerns:

Health Concern	Family Relative	Health Concern	Family Relative
Alcoholism		High blood pressure	
Allergies		Heart disease	
Alzheimers or dementia		Infertility	
Anemia		Intestinal disease	
Arthritis		Learning disability	
Asthma		Liver disease	
Easy bleeding/bruising		Mental Illness (specify)	
Cancer (specify)		Migraine Headaches	
Diabetes		Neurological disorders	
Drug Addiction		Obesity	
Skin Diseases		Osteoporosis	
Epilepsy/Seizures		Stroke	
Genetic Disorders (specify)		Suicide	
Glaucoma		Thyroid problems	
Gout		Tuberculosis (TB)	
Sexually transmitted Disease (specify)		Other:	

Please indicate if any of your child's blood relatives are deceased, age at time of death, and cause of death:
_____
_____

DIET

Please indicate the number of times per week that your child eats or drinks the following:

Food	# /wk	Food	# /wk	Food	# /wk
Fruits/Fruit juices		Soy products (tofu, soy milk, etc.)		Fast food (MacDonalds, etc.)	
Vegetables/Vegetable juices		Soft drinks (regular)		Coffee	
Luncheon meat/smoked meat		Soft drinks (diet)		Regular Tea	
White flour/white rice products		Salty snack foods (chips, etc.)		Herbal tea/Green tea	
Margerine		Sweets (candies, cookies, etc.)		Wine	
Milk/Cheese Products		Artificial sweeteners (Splenda, etc.)		Other alcoholic drinks	
Microwaved foods		Meal replacement bars/drinks		Glasses of water per day:	

What is the primary source of your child's drinking water? □Tap □Well □Bottled (spring) □Filtered □Distilled

Is there anything about your child's diet you would like to change?

_____

_____

On average how many meals does your child eat per day? 1 2 3 4 5 > 5

Which is usually your child's largest meal? Breakfast Lunch Dinner

List any foods that your child craves regularly: _____

List any foods you exclude from your child's diet: _____

Does your child follow a specific diet regime? Vegetarian Vegan Other _____

Does your child consume organic foods? Never 1-3x/wk 3-5x/wk 5-7x/wk Daily

Do you monitor your child's intake of Fat Salt Sugar Fiber Carbohydrate Protein

LIFESTYLE

How many times per week does your child exercise? Never < 1/wk 1-3/wk 3-5/wk >5/wk

What types of exercise does your child do? _____

How long does your child spend exercising each time? _____

Please indicate the amount of time your child spends doing the following activities on a typical day:

Activity	Time (hrs)	Activity	Time (hrs)
Computer		Relaxing	
Arts&Crafts/Coloring		Sleeping	
Eating		Playing video games	
Exercising		Time spent inside a building	
Listening to Music		Time spent outdoors	
Personal Hygiene		Watching Television	
Reading			

How many hours of direct sunlight is your child exposed to each week in the summer? _____ winter? _____
Do you apply sunscreen regularly?Yes No
Does anyone in household smoke? Yes (# packs per day _____) □Never smoked
Smoked in the past (# of years _____; # packs per day ____; Year that you quit___)
Regularly exposed to second hand smoke

ENVIRONMENTAL EXPOSURES

Which of the following is your child routinely exposed to?

Forced Air	Radiant Heat	□Gas Heat	□Oil Heat	□Food cooked on BBQ
Wood Stove	□Air Conditioning	□Electric Blanket	□Gas Fumes	□Microwave
Feather Pillow	□Heated Waterbed	□Computer Screen	□Factory Fumes	□Mould/mildew
Air Pollution	□Hydro Towers	□Chemical Spray	□Pesticides	□Paint fumes
Makeup/body creams	□Perfumes/Colognes	□Nail Polish	□Electric Heat	□Air fresheners
Cleaning Products	□Chlorinated Water	□Other (Specify) _____		

Do you have pets in your home? □Yes □No Type of pets? _____
Is your child's home/daycare/school environment excessively □Damp □Dry □Hot □Cold

REVIEW OF SYSTEMS

Height: _____ Weight:_____ Weight 1 year ago: _____

Have your child had an unexplained loss of weight of 5 lbs or more in the past 6 months? Yes No

Rate your child's energy level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Rate your child's stress level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

At what time of day is your child's energy the best? _____ the worst? _____

How many hours of sleep does your child get per night? _____

Please place a checkmark if your child is currently experiencing or has experienced any of the following:

Immune:

Chronic infections	□Ear Infections	□Cold sores	□Frequent sore throats
Frequent antibiotics	□Frequent colds/flus	□Swollen glands/nodes	□Slow wound healing

Neurological:

Paralysis	Muscle weakness	Vertigo	Loss of balance
Numbness	Tingling	Loss of memory	Lack of coordination
Seizures/Epilepsy	Concussion	Loss of sensation	

Skin, Hair and Nails:

Rashes	Itching	Hair loss	Night sweats
Lumps/Abcesses	Strong body odour	Change in the size, shape,	Brittle nails
Excessive perspiration	Dry skin	colour of a mole or freckle	Warts
Eczema/psoriasis	Thinning hair	Boils	Recent moles

Head, Eyes, Ears, Nose and Throat:

Headaches	Poor night vision	Earaches	Teeth grinding
Migraine headaches	Dry eyes	Impaired hearing	Gum problems
Visual disturbances	Excessive tearing	Ringing in ears	Cavities
Colour blindness	Blurry vision	Loss of hearing	Throat hoarseness
Near sighted	Poor sense of smell	Itchy ear canal	Mercury fillings
Far sighted	Loss of taste/smell	Excessive ear wax	Sinus infections
Astigmatism	Post nasal drip	Facial pain/tics	Eye pain/strain
Nose bleeds	Sores in mouth		

Respiratory System:

Difficulty breathing	Bronchitis	Emphysema	Coughing blood
Chronic cough	Asthma	Shortness of breath	Throat phlegm
Wheezing	Pain while breathing		

Cardiovascular System:

High blood pressure	Fainting	
Low blood pressure	Phlebitis	Artificial valve Cold
Irregular heartbeat	□ Chest pain	hands or feet Heart
Swelling of limbs	Dizziness	murmurs

Gastrointestinal System:

Indigestion	Vomiting	Incomplete bowel movements	
Gas or burping	Black stool	Mucus in stool	Undigested food in stool
Bad breath	Abdominal pain	Hard stool	Change in appetite
Trouble swallowing	Diarrhea	Floating stool	Change in thirst
Nausea	Constipation	Blood in stool	Hemorrhoids
Bloating	Chronic laxative use	Rectal pain	Itching around rectum
Colon trouble	Known parasites	Gallbladder problems	Jaundice

How often do your child have a bowel movement? _____

Genito-urinary System:

Frequent urination	Blood in urine	Awaken to urinate	
Urgency on urination	Mucus in urine	Strong urine odour	Kidney infection
Pain on urination	Incontinence	Bladder infections	Strain to urinate

Muscle, Bones and Joints:

Neck pain	Muscle pain	Juvenile Arthritis	Artificial joint/limb
Back pain	Muscle weakness	Bursitis	Other pain

Male Reproductive System:

Hernia	Testicular mass/pain	Circumcised: □yes □no
Discharges or sores	Undescended teste	

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Female Reproductive System:

Vaginal discharge	Vaginal Bleeding
Vaginal dryness	Sores, growths, lumps
Vaginal itching	Odour to discharge

Mental/Emotional:

Prolonged sadness/grief	Easily angered	Mental illness	Panic attacks
Anxiety/Nervousness	Indecision	Mood swings	Memory problems
Depression	Irritability	Phobia	

What were the major stresses in your child's life? Are any of these still affecting your child?

1._____

2._____

Has there been an event or illness from which your child has never fully recovered from?

_____

_____

_____

What are your child's hobbies and interests?

_____

_____

_____

SIGNATURE

I, _____ attest that the information provided is true and accurate to the best of my knowledge.

Guardian Signature: _____ Witness: _____

Date: _____

Consent to Services Form_____

Pediatric Fees

Office Visits:

Initial Consultation (90 minutes) *In-depth history taking, complaint-oriented physical exam, urinalysis*	$175.50
2nd Visit (60 minutes) *General screening physical exam, necessary lab tests, initiation of treatment plan and nutritional consultation*	$117
Follow Up Consultations *Continuation and monitoring of treatment plan* 60 minutes 45 minutes 30 minutes 15 minutes Acupuncture Treatments (5-10 sessions)	 $126 $94.50 $63 $31.50 $63 each session
****All visit fees are tax exempt as of Feb 2014***	

Telephone and Skype Consultations*: Follow up visit fees apply

** Please note that there is no charge for telephone consultations regarding clarification of treatment protocols. Telephone consults can be scheduled for patients in lieu of an in-office visit only after an initial visit has been conducted and a treatment plan has been initiated.*

Diagnostic Services and Naturopathic Medicines

The Somerset Health & Wellness Centre has functional laboratory services provided by Gamma-Dynacare and Lifelabs. This enables our doctors to perform comprehensive blood work, urine and stool testing, as well as special tests using saliva and hair. In addition, they can administer Vitamin B12 and folic acid via intramuscular injection. OHIP does not cover laboratory services requested by naturopathic doctors, therefore, patients are required to pay for these services at the time of testing.

The Somerset Health & Wellness Centre also carries a limited selection of professional quality products that are not available through health food stores. OHIP does not cover the cost of these products, thus, patients are required to pay for products that they choose to purchase from their naturopathic doctor.

Booking Appointments

Please schedule your child's appointments, including pick-up of prescribed products, in advance. Please plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

Payment for Services

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain this receipt for your insurance or income tax claims, if applicable. Fees may be paid by cash, cheque, direct debit, Visa or Mastercard. We do not accept American Express. A surcharge of $35.00 will apply to any NSF cheques. Please note that refunds are not available for medical services rendered, included lab tests performed, and products that have been sold. Extended insurance plans often offer limited coverage for naturopathic medicine. Plans and policies differ, so please check with your provider regarding your child's coverage and claim procedures.

Cancelled and Missed Appointments

Please ensure to give at least two business days cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, the full cost of the appointment will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the doctor.

Confidentiality

Everything that you communicate directly or indirectly to the doctor is confidential unless you give written permission to disclose information to a third party. Confidentiality is respected at all times.
It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with a court ordered subpoena;
3. prevent harm to your child or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient
5. share information in a supervision format

In Case of Emergency

Emergency services are not available at The Somerset Health & Wellness Centre. In case of an emergency, patients should dial 911, or proceed to the Emergency Department of the nearest hospital.

Statement of Acknowledgment

I, _____ have read, understood and agree to the contents herein
(print name)

Guardian Signature: _____

Witness: _____

Date: _____

****Please sign and return this form to Somerset Health & Wellness Centre on your child's first visit***

Privacy Policy Consent Form

Privacy of your child's personal information is an important part of the naturopathic clinic at the Somerset Health and Wellness Centre. We are committed to collecting, using and disclosing your child's personal information responsibly.

All staff members who come in contact with your child's personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in appropriate use and protection of your child's information.

Our privacy policy outlines what the naturopathic clinic at the Somerset Health and Wellness Centre is doing to ensure that:

- Only necessary information is collected about you;
- We only share your child's information with your consent;
- Storage, retention and destruction of your child's personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation (PHIPA) and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

The naturopathic clinic at the Somerset Health and Wellness Centre understands the importance of protecting your child's personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your child's information.

The clinic will collect, use and disclose information about your child for the following purposes:

- To assess your child's health concerns, provide health care and advise you of treatment options
- To establish and maintain contact with you, and remind you of upcoming appointments
- To send you newsletters, educational materials, and other information mailings
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements

Statement of Consent

I have reviewed the above information that explains how the naturopathic clinic at The Somerset Health and Wellness Centre will use my personal information, and the steps your clinic is taking to protect my information. I agree that I am giving my informed consent to the collection, use and/or disclosure of my personal information as outlined above.

I agree that the naturopathic clinic at The Somerset Health and Wellness Centre can collect, use and disclose personal information about _____ as set out above.
(Print Patient's Name)

_____ _____ _____
Guardian Signature Date Signature of Witness

****Please sign and return this form to Somerset Health & Wellness Centre on your child's first visit.***

Consent to Treat Form

Dear New Patient,

We would like to take this opportunity to welcome you to the naturopathic clinic at The Somerset Health and Wellness Centre. This practice utilizes the principles and practice of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

The doctor will conduct a thorough case history, which will include a physical exam. Specific blood and/or urinary laboratory reports may be used as part of the diagnostic work-up. The doctor may recommend that you take certain products as part of your child's treatment plan. Please note that patients are free to choose where they purchase the recommended products, but that certain professional product lines are only available through licensed Naturopathic Doctors.

Statement of Consent

As the legal guardian of _____, I, _____ have read the
(child's name) (your name)
information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I acknowledge that my naturopathic doctor endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, as many factors will be important in determining actual results. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over -the-counter drugs and supplements.

The slight health risks of some naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations.

I also acknowledge that I have the ability to accept or reject this care of my own free will and choice. I give permission and consent to the doctors of Somerset Health and Wellness Centre to provide naturopathic consultation, assessment and/or treatment to me and/or my child _____ who is my son/daughter.

Patient (or Parent/Guardian) Signature: _____

Witness : _____

Date: _____

****Please sign and return this form to Somerset Health & Wellness Centre on your child's first visit.***