



Patient record: Paediatrics

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Parent or Guardian

Guardian full name

Relationship to child

☐ Mother ☐ Father ☐ Legal guardian ☐ Other

Guardian phone

2. Birth History

Gestational age (weeks)

Birth weight

Mode of delivery

☐ Vaginal ☐ Caesarean

Perinatal complications?

☐ Yes ☐ No

If yes, give details:

NICU admission?

☐ Yes ☐ No

If yes, give details:

3. Growth and Development

Growth measurements

Date	Weight	Height	Head circumference	Percentile

Developmental milestones

4. Immunisation

Vaccination record

Vaccine	Dose	Date	Batch no.

Post-vaccination reactions?

☐ Yes ☐ No

If yes, give details:

5. Medical History

Allergies?

☐ Yes ☐ No

If yes, give details:

Asthma or respiratory problems?

☐ Yes ☐ No

If yes, give details:

Hospital admissions?

☐ Yes ☐ No

If yes, give details:

Chronic conditions and medication

Family history

6. Examination and Plan

Physical examination

Diagnosis and plan

7. Guardian Consent

Guardian consent

1. I have been informed in an understandable way about the child's diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.
2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.
3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.
4. I authorize the paediatrician and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me as parent or legal guardian.
5. I have been informed that I have the right to refuse the child's treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.
6. I sign as the parent or legal guardian of the minor patient and confirm that I have the authority to do so.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

Signature

Date

dd/mm/yyyy