

Medical procedures/surgeries/tests

Child's name _____ Date of birth _____

Please complete the information below. Remember to include any and all procedures that may have included sedation.

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|--|------------------------|
| Name of procedure/surgery/test: | Date performed: |
| Performed at (hospital/clinic): | Performed by: |
| Dates of hospitalization (if applicable): | |
| Anesthesia/special considerations: | |
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| Other notes: | |
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