CHAMPAGNE AND AISHIHIK FIRST NATIONS

Prenatal Nutrition Program Application

Date:		
Name of Applicant:		
Name of Spouse:		
Address Postal Code:		
Phone Number:	Email:	
Applicant Birth Date:		
Expected Due Date:		
Date of 1st Ultrasound:	Date of 2nd Ultrasound:	
Smoker: ☐ Yes ☐ No	Prescription Drugs?	
Quit after discovery of pregnancy? ☐ Yes ☐ No How long?	Alcohol Consumption?	
	Gestational Diabetes?	
Special Diet?		
Any complications regarding pregnancy?		
Family Doctor (Name and Number):		
In case of emergency, please contact:		
Please list any allergies you or your child have:		
Please list any medical conditions you or your child have:		

*All information given is confidential

Questions or concerns?
Marion Primozic (867) 456-6888 ext. 320 or 332-5262