Health Record

Part A

Child's Name _____ Sex _____

Address _____ City _____

Date of Birth _____ Home Phone _____ Work Phone _____

Mother's Name _____ Father's Name _____

Parent's Place of Employment _____

Child's Physician _____ Physician Address _____

Physician Phone _____

IMMUNIZATIONS (To be completed by health care personnel -*Requires: Month—Day—Year Received)*

DTaP _____ _____ _____ _____ _____ Tdap _____

HIB _____ _____ _____ _____

Polio _____ _____ _____ _____

HEP-B _____ _____ _____ HEP-A _____ _____

MMR _____ _____ Rotavirus _____ _____ _____

Varicella _____ _____ Other _____ _____ _____ _____

Prevnar _____ _____ _____ _____

HPV _____ _____ _____

Urinalysis: PH_____ Protein_____ Glucose_____ Ketones_____ Blood_____ Leuk_____

Part B

PHYSICAL ASSESSMENT *(TO BE COMPLETED BY PHYSICIAN) Date of exam*_____

Child's Name _____

HT_____ WT_____ B/P_____ P_____

	Normal	Abnormal	Explanation
General Health			
General Nutrition			
Eyes			
E.N.T.			
Chest			
Heart			
Lungs			
Abdomen			
Genitalia			
Extremities			

If child is on Medication, please list name of drug, dosage, frequency & reason _____

Known Allergies to _____

Date _____ **Physician's Signature** _____