

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 _____