Health Record

Part A

Child's Name ______________________________ Sex __________

Address ______________________________ City __________

Date of Birth __________ Home Phone ______________ Work Phone ______________

Father's Name ______________________ Mother's Maiden 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 _______ _______ _______ _______ _______

HIB _______ _______ _______ _______

Polio _______ _______ _______ _______

HEP-B _______ _______ _______ HEP-A _______ _______

MMR _______ _______

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** ______________