Health Record

Part A

Child's name____

Date of Birth_____________ Gender__________

Address____ City_________________________

Father's Name_________________________ Cell Phone________________ Work Phone___________

Mother's Name________________________ Cell Phone________________ Work Phone___________

Child's Physician_______________________ Physician's Phone_____________________________

Physician's Address____________________________________ City_________________________

IMMUNIZATIONS (To be completed by health care personnel. Requires: Month/Day/Year received)

DTap ________ ________ ________ ________ ________

HIB ________ ________ ________ ________

Polio ________ ________ ________ ________

HEP-B ________ ________ ________ HEP-A ________ ________

MMR ________ ________ Rotavirus ________ ________ ________ ________

Varicella________ ________ Other ____________________ ________ ________

Prevnar ________ ________ ________ ________

HPV ________ ________ ________

Part B
PHYSICAL ASSESSMENT (To be completed by physician) Date of Assessment__________________

HT________ WT________ B/P________ P________ Resp________ Temp________

	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 and reason
____

Known allergies____

Date________________ Physician's Signature____