HEALTH RECORD
State Form 23923 (R3/7-03)

Child's Name _____ Birth Date____/____/____
(Last) (First) Admission Date ____/____/____

Street Address _____ City _____ Zip _____

Child lives with _____ Name _____ Phone _____

MEDICAL HISTORY

Communicable Disease	Month/Year	Condition	Explain if present
Measles		Allergies	
Rubella (German Measles)			
Chickenpox (Varicella)		Physical	
Mumps		Limitations:	
Scarlet Fever			
Whooping Cough		Other:	
Hepatitis B			
Other:			

PHYSICAL EXAMINATION

Date of Exam _____ Age of Child _____

Skin _____	Heart _____
Lymph nodes _____	Lungs _____
Eyes _____	Abdomen _____
Ears _____	Genitalia _____
Nasopharynx _____	Skeleton _____
Teeth & Mouth _____	Other _____

Note any unusual findings: _____

Does this child have any health condition that would be hazardous to him/herself or to other children in a group setting as a result of participation in normal activities (including sports)? No _____ Yes _____. If "Yes", what modification of normal activities would be necessary to protect the child and his/her classmates? _____

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities?
No _____ Yes _____ Explain: _____

(Over)

HISTORY OF IMMUNIZATIONS (Indicate month/day/year)

	1	2	3	4	5
DTaP/DT/Td/TD					

	1	2	3	4
OPV, IPV				

	1	2	3	4
Hib				

	1	2	3
Hepatitis B			

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

	1	2	3	4
PCV7				

Name of Physician Completing Form: _____ Phone Number: _____

(Please Print)

Physician's Signature: _____

ADDITIONAL NOTES AND INSTRUCTIONS

_____

_____

_____

_____

_____