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 Diseases	Month/Year	Condition	Explain if Present
Measles	____/____	Allergies: _____	_____
Rubella (German Measles)	____/____	_____	_____
Chickenpox (Varicella)	____/____	_____	_____
Mumps	____/____	_____	_____
Scarlet Fever	____/____	Physical Limitations:	_____
Whooping Cough	____/____	_____	_____
Hepatitis B	____/____	_____	_____
Other: _____	____/____	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 the 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/DT					

	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

_____

_____

_____

_____

_____