

Health Record

Child's Name: _____ **Date:** _____
Child's Birthdate _____ **Age at Examination** _____
Height _____ **Weight** _____
General Physical Condition _____

Immunization Record (give date of each immunization and booster)

DPT	Polio	Typhoid	Measles	Vaccine	Rubella	Mumps	Smallpox
1							
2							
3							
Booster							
Booster							

Date and Result of Tuberculin Test _____

Dates When Child Had:

German Measles (Rubella)	Measles (Rubeola)	Chicken Pox	Whooping Cough	Mumps	Rheumatic Fever
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Does Child Have Any Special Health Problems? (Hay Fever, Asthma, Allergies, Etc?)

Yes No Specify and Give Dates: _____

Has Child Had Any Serious Illnesses or Accidents? Surgery?

Yes No Specify and Give Dates: _____

Does Child Have Any Physical Handicap?

Yes No Specify and Give Dates: _____

How Frequently Does Child Have:

Colds	Sore Throats
Diarrhea	Earache
Vomiting	Constipation
Other	

The above names child has been examined and found to be in satisfactory physical condition and may be admitted to the Center without endangering the health of the group.

Signed: _____ Date: _____

(Physician or Other Qualified Provider of Health Services)

Address: _____ Telephone: _____

