HEALTH RECORD

INFORMATION REGARDING CHILD

_____ D.O.B. _____ Sex _____

Last Name First Name

Address _____

City *Zip*

Medical Care: (Doctor or Clinic) Name _____

Address _____

Phone _____

DISEASE HISTORY DATES: *Please circle*

Measles	*Yes*	*No*	Scarlet Fever	*Yes*	*No*	German Measles	*Yes*	*No*
Mumps	*Yes*	*No*	Chicken Pox	*Yes*	*No*	Whooping Cough	*Yes*	*No*
						Other	*Yes*	*No*

HISTORY, FINDING AND RECOMMENDATIONS to be filled in by Doctor or Clinic

Pre-Admission Examination:

1. History _____

2. Physical Examination: (Please check and describe positive findings)

_____ *Eyes, Ears, Nose and Throat*	_____ *Heart and Lungs*	_____ *Abdomen*
_____ *Skin and Scalp*	_____ *Extremities*	_____ *Other*
_____ *Urine (optional)*		

3. Comments and recommendations of Physician _____

Date	Other Examinations and Progress Notes by Physician and/or Nurse	Signature

HEALTH RECORD

Physician's Report (continued)

HEIGHT AND WEIGHT RECORD

Date: _____ Height _____ (inches) Weight _____(lbs.)

VACCINE	Date Given m/d/y	Age		VACCINE	Date Given m/d/y	Age
HepB1				PCV1		
HepB2				PCV2		
Hepb3				PCV3		
RV1				PCV4		
RV2				IPV1		
RV3				IPV2		
DTaP1				IPV3		
DTaP2				IPV4		
DTaP3				MMR1		
DTaP4				MMR2		
DTaP5				VAR1		
Hib1				VAR22		
Hib2				HepA		
Hib3				TB Test		
Hib4				Influenza		

I certify that the above named child is free of communicable diseases and is physically and mentally able to participate in group activities.

_____ _____

Date Physician's Stamp and Signature

_____ _____

Phone No. Address