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

Please have your child's medical provider complete this form prior to the first day of enrollment.

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