

Child's Name _____
Last First Date of Birth

Parent(s)/Guardian's Name _____
Last First

Record of Immunizations

DPT-1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____ Tdap _____

Polio-1st _____ 2nd _____ 3rd _____ 4th _____ Booster _____

Measles/MMR- 1st _____ 2nd _____ HIB- 1st _____ 2nd _____ 3rd _____

Hepatitis B- 1st _____ 2nd _____ 3rd _____ Varicella _____

Influenza _____ Pneumonia _____ Meningococcal _____ Mantoux _____ Result _____
Health History

Chicken Pox _____

Congenital Defects _____

Eczema/Psoriasis _____

History of Heart Trouble _____

Ear Infections _____

History of Lung Trouble _____

Rheumatic Fever _____

Family History of Diabetes _____

Seizure Disorder _____

Other _____

Asthma _____

Operations _____

Sinusitis _____

Hospitalizations _____

Diabetes _____

Under Doctor's Care _____

Allergies _____

Doctor's Examination

Height _____ Weight _____

Blood Pressure _____

Posture _____

Feet _____

Extremities _____

Heart _____

Nutrition _____

Nervous System _____

Skin _____

Lungs _____

Teeth _____

Abdomen _____

Throat _____

Hernia _____

Ears _____

Genitals _____

Eyes _____

General Condition _____

Restrictions _____

_____ Date

_____ Physician's Signature

_____ Physician's stamp