10040 Lafayette-Plain City Road
Plain City, OH 43064

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# Health Record

## Part A

Child's Full Name___________________________________ Sex_____________ Date of Birth ________

Address______________________________________________________ City______________________

Home Phone ________________ Work Phone_________________ Cell Phone_____________________

Mother/Guardian's Name______________________Father/Guardian'sName ________________________

Parent's Place of Employment ______________________________________________________________

Child's Physician ___________________________ Physician's Phone ____________________________

Physician's Address _________________________________________________________________________

**Immunizations** (To be completed by health care personnel; Requires: Month-Day-Year Received)

| | | | | | |
|---|---|---|---|---|---|
| DTaP | | | | | |
| Tdap | | | | | |
| HIB | | | | | |
| Polio | | | | | |
| HEP-B | | | | | |
| HEP-A | | | | | |
| MMR | | | | | |
| Rotavirus | | | | | |
| Varicella | | | | | |
| Prevnar | | | | | |
| HPV | | | | | |
| Other | | | | | |

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## Part B

**Physical Assessment** (To be completed by Physician) Date of Exam _________________

Height___________ Weight ___________ Blood pressure________________ Pulse ______________

| | Normal | Abnormal | Explanation |
|---|---|---|---|
| General Health | | | |
| General Nutrition | | | |
| Eyes | | | |
| E.N.T. | | | |
| Chest | | | |
| Heart | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia | | | |
| Extremities | | | |

If child is on medication, please list name of drug, dosage, frequency & reason:_______________________

______________________________________________________________________________________

Known allergies to: _____________________________________________________________________

Date ____________________________ Physician's Signature ______________________________