Return within one month of enrollment

CHILD'S HEALTH RECORD

Indiana State Board of Health

Child's Name ______________________________ Birth Date ________________________

Street Address ______________________________ City _______________ Zip ___________

Child lives with _________________ Name _____________________ Phone _____________
Relationship

Medical History

Communicable Disease	Month/Year	Condition	Explain if present
Measles	_____/_____	Allergies	__________________
Rubella (Ger. Measles)	_____/_____		
Chicken Pox	_____/_____		
Scarlet Fever	_____/_____	Other	__________________
Whooping Cough	_____/_____		
Other	_____/_____		

-

Physical Examination

-

Date of Exam:

Skin:	Heart:
Lymphnodes:	Lungs:
Eyes:	Abdomen:
Ears:	Genitalia:
Nasopharynx:	Skeleton:
Teeth and Mouth:	Other:

Note any other unusual finding:

Does this child have any health conditions that would be hazardous either to him/herself or to other children in a group setting as a result of participation in normal indoor and outdoor activities? No _____ Yes _____
If yes, please explain:

Have you prescribed any medications or special routines which should be included in the center's plan for this child's activities? No _____ Yes _____
If yes, please explain:

HISTORY OF IMMUNIZATION & TEST

(day/month/year)	1	2	3	4	5
DTP/TD					
IPV					
MMR					
Hib					
Hepatitis B					
Varicella					
Pneumococcal					

Name of Physician Completing Form: _________________________ Tel. No. ___________
please print

Physicians Signature: ___________________________________