

# Immaculate Conception School

## Child's Health Record

Child's Name \_\_\_\_\_  
(Last) (First) (MI)

Birth Date \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Other: \_\_\_\_\_

In Case of Emergency \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Medical Care: Family Physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Medical History: Has the child had any of the following medical conditions? What Year?

Asthma \_\_\_\_\_

Measles \_\_\_\_\_

Mumps \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Scarlet fever \_\_\_\_\_

Whooping cough \_\_\_\_\_

Diphtheria \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Epilepsy \_\_\_\_\_

Heart Disease \_\_\_\_\_

Pneumonia \_\_\_\_\_

Poliomyelitis \_\_\_\_\_

Diabetes \_\_\_\_\_

Hernia \_\_\_\_\_

Otitis Media \_\_\_\_\_

Convulsions \_\_\_\_\_

Mental Retardation \_\_\_\_\_

Hepatitis \_\_\_\_\_

Does the Child have any Allergies? \_\_\_\_\_

Does the Child have any special health needs? \_\_\_\_\_

Any Physical disability? \_\_\_\_\_

List any long term medications required during school hours: \_\_\_\_\_

Medications required after school/weekends: \_\_\_\_\_

**Immunization dates (mm/dd/yy) or attach documentation from MD office.**

DTaP/Tdap Polio MMR HIB HepB Varicella Meningococcal PCV Hep A Flu


TB/Mantoux (most recent) \_\_\_\_\_ Result \_\_\_\_\_

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Physical Exam Date: \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

General Appearance \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Lymph \_\_\_\_\_ Thyroid \_\_\_\_\_

Teeth \_\_\_\_\_ Throat \_\_\_\_\_ Nose \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_

GU \_\_\_\_\_ Extremities \_\_\_\_\_ Orthopedic \_\_\_\_\_ Neurological \_\_\_\_\_ Skin \_\_\_\_\_ Nutrition \_\_\_\_\_

Physical/Emotional Handicap(s) \_\_\_\_\_ Speech \_\_\_\_\_

Date \_\_\_\_\_ Physician's Name (print) \_\_\_\_\_

**(or attach copy of exam)**

Physician's Signature \_\_\_\_\_