For Year 20___- 20___ Grade_____

Immaculate Conception School

Child's Health Record

Child's Name _____ _____ ____
(Last) (First) (MI)
Birth Date_____ Sex: Male____ Female____

Address_____ City_____ State_____ Zip_____
Email:_____
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?

ADD/ADHD_____
Asthma_____
Autism Spectrum Disorders_____
Chicken Pox_____
Chronic Otitis Media_____
Concussion/TBI_____
Congenital Disorder_____
Convulsions/seizures_____
Diabetes_____
Diphtheria_____
Heart Disease_____
Hematological Disorders_____
Hepatitis_____
Hernia_____
Juvenile Rheumatoid Arthritis_____
Kidney Disease_____
Lyme Disease_____
Measles_____
Mononucleosis_____
Mumps_____
Neuromuscular Disorder_____
Pertussis/Whooping cough_____
Pneumonia_____
Scarlet fever_____

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	Polio	MMR	HIB	HepB	Varicella	Meningio	PCV	Hep A	Flu	HPV Tdap

TB/Mantoux (most recent) _____ Result _____Other Immunizations_____
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Physical Exam Date:_____Age_____ Height_____ Weight_____BP_____
GeneralAppearance_____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 _____