

MEDICAL RECORD

Child's Name _____ Date of Birth _____
Family Doctor _____ Phone # _____
Address _____ MSI # _____

Physical Examination:

Height: _____	Hearing: _____
Weight: _____	Mouth and Throat: _____
Head: _____	Abdomen: _____
Skin: _____	Skeletal: _____
Eyes: _____	C.N.S. _____
Blood Type: _____	Genito-Urinary: _____

Any History of:

Yes / No

Skin Condition _____
Ear Infections _____
Asthma, Bronchitis, Pneumonia _____
Convulsions: _____

Immunization Dates Against:

	Date		Date
DaPTP, Hib (2mos)	_____	Prevnar	_____
DaPTP, Hib (4mos)	_____	Prevnar	_____
DaPTP, Hib (6mos)	_____	MMR	_____
DaPTP, Hib (18mos)	_____	Varicella	_____
Men group C	_____	Other	_____

Childhood Diseases:

Yes / No

Measles _____
Chicken Pox _____
Whooping Cough _____
German Measles _____
Mumps _____
Other: _____

Any special conditions and / or treatment necessary:

Any recommendation for diet or rest:

I, _____, hereby certify that _____
is free from communicable diseases.

Parent's signature: _____ Date: _____