Health History & Immunization Record

Child's Full Name: _____

Date of Birth: _____

Gender: _____

Pediatrician's Name: _____

Phone Number: _____

Address: _____

Hospital Preference: _____

Does your child have any known allergies (food, medications, environmental)?

_____

List any medications your child is currently taking:

_____

Has your child had any of the following (check if yes):

[ ] Asthma [ ] Diabetes [ ] Seizures [ ] Heart Condition

[ ] Frequent Ear Infections [ ] Vision or Hearing Problems

[ ] Other (please describe): _____

Any surgeries, hospitalizations, or serious injuries?

_____

IMMUNIZATION RECORD (attach copy if available):

Please list all vaccines received and approximate dates:

_____

_____

Does your child have a current TB Test on file? [ ] Yes [ ] No

Date of last TB Test: _____

Does your child have any physical limitations or restrictions?

_____

Parent/Guardian Signature: _____ Date: _____