

Health History & Immunization Record Form

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name(s): _____

Please complete the following health information for your child:

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

Yes No

If yes, please explain: _____

Does your child have any chronic conditions or medical concerns (asthma, diabetes, etc.)?

Yes No

If yes, please describe: _____

Does your child take any regular medications?

Yes No

If yes, please list: _____

Date of last physical exam: _____

Immunizations:

I have provided a copy of my child's current immunization record.

My child is exempt from immunizations for the following reason: _____

Parent/Guardian Signature: _____

Date: _____