

Health Information Form *for Children*



IDENTIFICATION

Name				<i>In Case of Emergency Notify:</i>	
Date of Birth		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Name	
Height	Weight	Eye Color	Blood/RH Type	Relationship	Phone
Mother's Name				Obstetrician	Phone
Address				Pediatrician	Phone
City	State	Zip		Other Physician (<i>Indicate Specialty</i>)	Phone
Home Phone	Work Phone			Pharmacy	Phone
Father's Name				Other	Phone
Address				Other	Phone
City	State	Zip		Other	Phone
Home Phone	Work Phone			Other	Phone
Languages Spoken				Other	Phone

BIRTH DATA

Hospital
Weight
Length
Physician
Perinatal Problems
Apgar Score

INFECTIOUS DISEASES

Disease	Age	Date	Remarks
Chickenpox			
Measles			
Rubella			
Hepatitis			
Mumps			
Polio			
Pneumonia			
Pertussis / Whooping Cough			
Scarlet Fever			
Other			

IMMUNIZATIONS

Immunization for	Age	Date	BOOSTER 1		BOOSTER 2		BOOSTER 3	
			Age	Date	Age	Date	Age	Date
Diphtheria								
Pertussis / Whooping Cough								
Tetanus								
Polio								
Smallpox								
Typhoid								
Rubella								
Mumps								
Measles								
Tuberculosis								
Hepatitis B								
Other								

