10040 Lafayette-Plain City Road
Plain City, OH 43064

Phone: (614) 873-3130
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Health Record

Part A

Child's Full Name_____ Sex_____ Date of Birth _____

Address_____ City_____

Home Phone _____ Work Phone_____ Cell Phone_____

Mother/Guardian's Name_____Father/Guardian'sName _____

Parent's Place of Employment _____

Child's Physician _____ Physician's Phone _____

Physician's Address _____

Immunizations (To be completed by health care personnel; Requires: Month-Day-Year Received)

DTaP					
Tdap					
HIB					
Polio					
HEP-B					
HEP-A					
MMR					
Rotavirus					
Varicella					
Prevnar					
HPV					
Other					

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Part B

Physical Assessment (To be completed by Physician) Date of Exam _____

Height_____ Weight _____ Blood pressure_____ Pulse _____

	Normal	Abnormal	Explanation
General Health			
General Nutrition			
Eyes			
E.N.T.			
Chest			
Heart			
Lungs			
Abdomen			
Genitalia			
Extremities			

If child is on medication, please list name of drug, dosage, frequency & reason:_____

_____

Known allergies to: _____

Date _____ Physician's Signature _____