Doctor's Health Record

Child's Name _____

Sex _____ Date of Birth _____

Name of Parent or Guardian _____

If tuberculin test given: Date _____ Result _____

If chest x-rayed: Date _____ Result _____

Surgery, accidents, serious illnesses, chronic or handicapping problems:

_____

Known allergies: _____

Known drug reactions and/or special diets_____

Medication currently being taken _____

Does child have any unusual health conditions or limitations? _____

If yes, please specify: _____

Comments and instructions for school _____

Doctor's signature _____ Date: _____

Doctor's name _____

Doctor's address _____

Doctor's phone number _____