



10040 Lafayette-Plain City Road Phone:
Plain City, OH 43064

(614) 873-3130
Fax: (614) 873-3699

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's Name _____
 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				
Pevnar				
HPV				
Menactra				
Other				

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 _____