HEALTH RECORD

Please have this form completed by a licensed health professional:
ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD TO THIS FORM

Child's Name____

Is the child able to participate in the normal activities of a school program?
❒Yes ❒No

Are there any restrictions on normal activities? ❒Yes ❒No
If yes, please specify:____

Does the child have any chronic medical condition that necessitates special attention? ❒Yes ❒No
If yes, please specify:____

Is the child taking any medication prescribed for long term continous use?
❒Yes ❒No
If yes, please explain:____
____
____

Has the child been hospitalized during the past 12 months? ❒Yes ❒No
If yes, please explain:____
____
____

Known Allergies: ____

Dietary Restrictions: ____

____
Physician's Signature **Date**

____
Parent's Signature **Date**

Please return this form with your child's current immunization record to the front office or fax them to: 713-723-6143