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 continuous 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