



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**