STUDENT HEALTH RECORD

Edgewood Preschool Cooperative

Child's Name_____ Birth Date_____/_____/_____
(Last) (First) (MI)

Street Address _____ City_____ ZIP _____

Child Lives With _____ Name _____ Phone _____
(Relationship)

MEDICAL HISTORY

Communicable Disease	Month/Year	Condition / Explain if Present
Measles	_____	Allergies : _____
Rubella (German Measles)	_____	_____
Chickenpox (Varicella)	_____	Handicapping Conditions:
Mumps	_____	_____
Scarlet Fever	_____	_____
Whooping Cough	_____	_____
Other _____	_____	Other: _____

PHYSICAL EXAMINATION

Date of Exam _____ Age of Child _____

Skin _____	Heart _____
Lymph Nodes _____	Lungs _____
Eyes _____	Abdomen _____
Ears _____	Genitalia _____
Nasopharynx _____	Skeleton _____
Teeth and mouth _____	Other _____

Note any unusual findings: _____
_____

Does this child have any health conditions that would be hazardous either to him/herself or to other children in a group setting as a result of participation in normal activities (including sports)? No ____ Yes ____ If yes, what modification of normal activities would be necessary to protect the child and his/her classmates? _____

Have you prescribed any medications or special routines that should be incorporated into the preschool's plans for this child's activities?
No ____ Yes _____ If yes, explain: _____

Name of Physician Completing Form: _____ Phone _____
(please print)

Physician's Signature _____

HISTORY OF IMMUNIZATIONS AND TESTS

(Indicate Month/Day/Year)

	1	2	3	4	5
DTaP/DTP/DT/Td					

	1	2	3	4
Polio				

2 3_

	1	2	3	4
HIB				

	1	2	3
Hepatitis B			

	1	2
Measles		
Mumps		
Rubella		

	1	2	3	4
PCV7 (Prevnar)				

	1
Varicella	

NOTE: To be considered adequately immunized a child 24 months through 59 months of age should have received 4 doses of DTaP/DTP/DT/Td, 3 doses of Polio, 1 dose of Measles Mumps and Rubella (MMR) given after the first birthday and 3 doses of Hib Vaccine. Any child 60 months of age or older should receive a 5th dose of DTaP/DTP/DT/Td, a 4th dose of Polio, a 2nd dose of Measles (usually given as an MMR) and 3 doses of Hepatitis B vaccine.

Name of Physician Completing Form: ______________________________ Phone ___________

(please print)

Physician's Signature ____

ADDITIONAL NOTES AND INSTRUCTIONS

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