## TO BE COMPLETED BY PARENT / HEALTH COORDINATOR FOR CLASSROOM USE

DATE OF LAST PHYSICAL EXAM:

MEDICAL HISTORY	NOTATIONS
ALLERGIES: DRUG OR FOOD	
SPECIAL MEDICAL PROBLEMS	
RECENT ILLNESS OR SURGERY	
PHYSICAL LIMITATIONS & HANDICAPS	
HEART CONDITION	
CHEST CONDITIONS	
ASTHMA	
CONVULSIONS	
RHEUMATIC FEVER	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
DIABETES	
STREP INFECTION	
CHILDHOOD DISEASES	

## **IMMUNIZATION RECORD**

DPT.	Polio	Dt. or Td.	Measles	Skin Test		X-Ray & Other	Tests
Monthly/Year	Monthly/Year	Month/Year	Month/Year	Month/Year	Results	Month/Year	Results
			NAME OF THE OWNER, OF THE OWNER, OF THE OWNER, OF THE OWNER, OWNER, OWNER, OWNER, OWNER, OWNER, OWNER, OWNER,				
				Dental	Vision	Hearing	