Health Information Form for Children

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IDENTIFICATION

Name

Date of Birth | Sex: ☐ Male ☐ Female

Height | Weight | Eye Color | Blood/RH Type

Mother's Name

Address

City | State | Zip

Home Phone | Work Phone

Father's Name

Address

City | State | Zip

Home Phone | Work Phone

Languages Spoken

In Case of Emergency Notify:

Name

Relationship | Phone

Obstetrician | Phone

Pediatrician | Phone

Other Physician (Indicate Specialty) | Phone

Pharmacy | Phone

Other | Phone

Other | Phone

Other | Phone

Other | Phone

Other | Phone

BIRTH

Hospital

Weight

Length

Physician

Perinatal Problems

Apgar Score

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HEALTH LOG

Chronological account of chronic, recurrent, or significant acute illness or injury, including birth defects, surgical procedures, ear infections etc.

Date	Nature of Health Problem	Remarks (e.g., medications, special tests, x-rays, length of hospital stay, surgery, etc.)

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MEDICATIONS

Update Regularly

Date Started	Current Prescriptions: Name / Dose / Frequency

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INFECTIOUS DISEASES

Disease	Age	Date	Remarks
Chickenpox			
Measles			
Rubella			
Hepatitis			
Mumps			
Polio			
Pneumonia			
Pertussis / Whooping Cough			
Scarlet Fever			
Other			

IMMUNIZATIONS

			BOOSTER 1		BOOSTER 2		BOOSTER 3	
Immunization for	Age	Date	Age	Date	Age	Date	Age	Date
Diphtheria								
Pertussis / Whooping Cough								
Tetanus								
Polio								
Smallpox								
Typhoid								
Rubella								
Mumps								
Measles								
Tuberculosis								
Hepatitis B								
Other								

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GROWTH AND DEVELOPMENT INFORMATION

Date	Age	Weight	Height	Functional Status (e.g., walking, talking, socialization)