Holy Family
EARLY CHILDHOOD
Achieve. Lead. Soar

SCHOOL AGE HEALTH RECORD

Child's Name _____
Address _____
Parent's Name _____
Grade School My Child Attends _____

Does your child have any medical conditions that we should know about? Such as asthma, seizure disorders, allergies. If yes, please explain

_____
_____
_____
_____
_____

Does your child take any medication on a regular basis? If yes, please explain

_____
_____
_____
_____
_____

My child's immunizations are all up to date. Yes _____ No _____

Date of last physical _____

Parent's Signature _____

Date _____

This form is valid for one year

Revised April 2015