Health Form

490 West Boot Road
West Chester, PA 19380-1112
610-696-8107

Child's Full Name _____ Birth Date _____

Parents' Names _____

Physician Name _____ Phone _____

Physician Address _____

Date of physical examination _____ Height ____ Weight ____ BP _____

Medical Conditions /problems relevant to school (i.e., speech, allergies, ear infections, tubes) _____

_____

Physician's Signature _____

IMMUNIZATIONS

	Date	Date	Date	Date	Date
DPT or DT					
Polio					
MMR					
Hepatitis B					
HIBS					
Varivax					

The HIBS vaccine is recommended, but not required. All other immunizations are required for school entry by the Commonwealth of PA.

List any significant health problem, serious injury, or surgery since birth: _____

_____

_____

Does this child experience any of the following conditions/problems:

Allergies _____ Gastrointestinal _____

Asthma _____ Orthopedic _____

Bladder _____ Seizure Disorder _____

Ear Infections/Tubes _____ Vision _____

Other _____

Speech/I.U. Services? ___yes ___ no How long? _____