

HEALTH INFORMATION FORM FOR CHILDREN

Child is hypersensitive, allergic or has adverse reactions to: _____

IDENTIFICATION

Name		Date of Birth		Languages Spoken	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Eye Color	Blood/RH Type	
Mother's Name			In Emergency Notify:		
Address			Telephone Number		
City		State	Zip		
Home Phone		Work Phone		Obstetrician	
Father's Name		Other Physician		Specialty	Phone
Address			Dentist		
City		State	Zip		
Home Phone		Work Phone		Pharmacy	
			Other		

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.)

BIRTH DATA

Hospital _____

Weight _____ Length _____ Physician _____

Perinatal Problems _____

Apgar Score _____

