



2720 E 86th St Indianapolis, IN 46240 (317) 643-4148 www.northeastcooperative.org

Health Form

Child's Name _____ Birth Date ____/____/____
 (Last) (First)

Street Address _____ City _____ Zip _____

Child lives with _____ Name _____ Phone _____

MEDICAL HISTORY

Communicable Disease	Month/ Year	Condition	Explain if present
Measles	_____	Allergies	_____
Rubella (German Measles)	_____	Physical	_____
Chickenpox (Varicella)	_____	Limitations	_____
Mumps	_____	Other: _____	_____
Scarlet Fever	_____	_____	_____
Whooping Cough	_____	_____	_____
Hepatitis B	_____	_____	_____
Other: _____	_____	_____	_____

PHYSICAL EXAMINATION

Date of Exam _____ Age of Child _____

Skin _____	Heart _____
Lymph Nodes _____	Lungs _____
Eyes _____	Abdomen _____
Ears _____	Genitalia _____
Nasopharynx _____	Skeleton _____
Teeth and Mouth _____	Other: _____

Note any unusual findings: _____

Does this child have any health condition that would be hazardous to him/ herself or to other children in a group setting for normal activities (including sports)? No ___ Yes ___ If "Yes", what modification of normal activities would be necessary for this child and his/ her classmates?

	1	2	3	4	5 (K)
DtaP/DT/Td					

	1	2	3	4 (K)
OPV, IPV				

	1	2	3	4
Hib				

	1	2	3 (K)
Hepatitis B			

	1	2 (K)
MMR		

	1	2
Varicella		

	1	2	3	4
PCV7				

Name of Physician Completing Form: _____

Phone number _____

Physician's Signature _____

ADDITIONAL NOTES AND INSTRUCTIONS
