

**Child's Health Record
Child Care Program
Muncie Area Career Center**

1. Child's Name _____ Parent or Guardian _____
2. Address _____ Telephone _____
3. Date of Birth _____ Height _____ Weight _____
4. Illness Record – Dates: Chicken Pox _____
Other _____
5. Immunizations – Dates:
DTP - _____

Polio - _____

HIB - _____

Hepatitis B - _____

MMR - _____

Chicken Pox - _____ TB Test Result _____

Licensed Physician

CODE: O - - Normal XX - - Needs medical attention OO - - Corrected

- | | |
|--|--|
| <p>7. Vision: Unassisted R _____ L _____</p> <p>8. Ears R _____ L _____
Hearing R _____ L _____</p> <p>9. Skin and scalp _____</p> <p>10. Teeth _____</p> <p>11. Nose _____</p> <p>12. Tonsils _____</p> <p>13. Glands of neck _____</p> <p>14. Thyroid _____</p> <p>15. Abdomen _____</p> <p>16. Lungs _____</p> <p>17. Heart _____</p> | <p>18. Musculo-skeletal System _____</p> <p>19. This child (should or should not) participate in physical education. _____</p> <p>20. Allergies _____</p> <p>21. Remarks _____

_____</p> |
|--|--|

Signed _____ Date: _____

Address _____ Phone: _____