

SCHOOL HEALTH EXAMINATION RECORD

School _____

Grade: _____

Child's Name:

Home Address:

Last	First	Middle	Birth Date	Street	City, State, Zip	Phone
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Father's or Guardian's Name			Place of Employment	Work Phone		
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Mother's or Guardian's Name			Place of Employment	Work Phone		
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Physician's Name			Physician's Address	Physician's Phone		
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Is there anything about your child that the teacher needs to know to understand him better?

List diseases and other serious illnesses, injuries, or health conditions your child has had and give dates (year only):

Does any relative or anyone in the home have tuberculosis, diabetes or other serious illnesses? No _____ Yes _____ If yes, describe below: