Child Health Record Form

Child's Information

- **Name: ____**
- **Age: ____**
- **Date of Birth: ___________________________________**
- **Parent/Guardian Name: ____________________________**
- **Contact Phone: ___________________________________**
- **Address: _______________________________________**

Vaccination Schedule

Vaccine Name	Date Given	Booster Due Date	Administered By
Polio			
Hepatitis A			
DTaP (Diphtheria)			
Influenza			

Health Concerns

- **Does the child have any allergies? ☐ Yes ☐ No**
  If yes, specify: ____________________________________
- **Does the child have any ongoing health conditions? ☐ Yes ☐ No**
  If yes, specify: ____________________________________

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Parental Consent

- ☐ **I consent to the sharing of this health information with the child's school and healthcare providers.**

Parent/Guardian Signature: ___________________________

Date: ____

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