Child's Health Record Form

Due Orientation Evening
ClearView Children's Center
537 Franklin Road, Franklin TN 37069
Office 615-599-7685
ccc@clearview.org

<u>This section to be completed by Parent or Guardian</u>:

Child's full name _____

Date of birth _____ Social Security number_____

Any evidence of: Hearing loss or difficulties? _____

Vision difficulties? _____

Speech difficulties? _____

List any: Hospitalizations _____

Operations _____

Other serious illnesses _____

Current medications taking _____

Allergies _____

<u>This Section to Be Completed by Physician</u> :

All immunizations are up-to-date _____ Yes _____

No If no, indicate reason _____

Results of tuberculin skin test (if needed) _____

Other remarks regarding physical condition _____

The above information is correct as of (date) _____

***Signature of physician*_____ *Phone*_____**

Address _____

Immunizations (list dates of latest inoculation or provide certificate of immunization)

DPT _____

Hib/Hep B _____

MMR _____

Polio IPV _____

Varicella _____

Prevnar _____