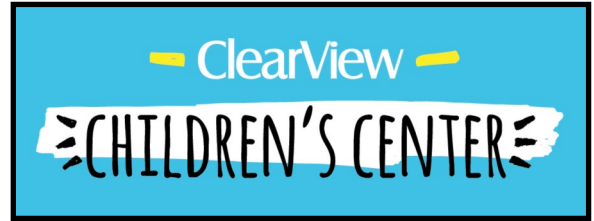


# Child's Health Record Form

Due August 1, 2019  
ClearView Children's Center  
537 Franklin Road, Franklin TN 37069  
Office 615-599-7685  
Fax: 615-591-3845  
ccc@clearview.org



## **This section to be completed by Parent or Guardian:**

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 \_\_\_\_\_

## **This Section to Be Completed by Physician :**

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 \_\_\_\_\_