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**A Child's Garden  
Child Health Information Record  
Form B: Physician to Complete Information**

Child's Name: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_

Date of most recent well child check \_\_\_\_\_

**Please attach a copy of most current immunization record.  
If record is not current, please explain below.**

What, if any, significant health problems has this child had in the past? \_\_\_\_\_

**Does this child have any of the following: (if yes, please describe)**

- |   |                          |     |                          |    |
|---|--------------------------|-----|--------------------------|----|
| Allergies   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Abnormal result on a hearing test   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Abnormal result on a vision test  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Recurring chronic illness/health problems                                       | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Disabilities (such as cerebral palsy,<br>seizure disorder, developmental delay) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

**If you answered "yes," to any of the above, please explain and provide any follow-up measures or appointments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What medications does this child take regularly?** \_\_\_\_\_

**If this child has any special health care or food needs, please describe the individualized care plan or any special instructions:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**