

**I. IDENTIFICATION**

Name (Last) (First) (Middle)

Date of Birth Male / Female

Address

City State Zip Code Country

Height Weight Ethnicity

Blood Type Eye Color

**Mother's Name** (Last) (First) (Middle)

Date of Birth

Address

City State Zip Code Country

Home Phone

Cell Phone

Email Address

**Father's Name** (Last) (First) (Middle)

Date of Birth

Address

City State Zip Code Country

Home Phone

Cell Phone

Email Address



**Personal Health Record**  
**...for children**

**II. EMERGENCY CONTACTS**

*In Case of emergency, please contact:*

Name (Last) (First) (Middle)

Maiden Name

Address

City State Zip Code Country

Home Phone

Cell Phone

**III. BIRTH**

Hospital

Weight

Length

Physician

Perinatal Problems

COMMENTS

#### **IV. INFECTIOUS DISEASES**

DISEASE	AGE	DATE
Chicken Pox		
H1N1 Flu		
Hepatitis		
Measles		
Mumps		
Whooping Cough		
Pneumonia		
Polio		
Rubella		
Scarlet Fever		



### **Personal Health Record ...for children**

#### **VI. GROWTH & DEVELOPMENT**

DATE	AGE	WEIGHT	HEIGHT

#### **V. IMMUNIZATIONS**

IMMUNIZATION	AGE	DATE
Diphtheria		
H1N1 Flu		
Hepatitis B		
Measles		
Mumps		
Whooping Cough		
Polio		
Rubella		
Tetanus		
Tuberculosis		
Typhoid		
OTHER		

