CHILD'S HEALTH RECORD

FBC WEE School
1200 9th St.
Wichita Falls, TX 76301
Fax (940) 766-1373

****This form must be completed and signed by a health care provider.**

Name of child _____Birth date _____

Height _____Weight _____

Is there a medical reason why immunizations cannot be given? Yes _____ No _____

If yes, please explain_____

Are all immunizations up to date? Yes _____ No _____

If no, please indicate reason _____

Please attach a copy of immunization records to this form.

GENERAL INFORMATION

Does child have any known allergies? _____

Please list any medications the child is taking of which school staff should be aware:

_____

Does child have any special needs of which staff should be aware?

_____

The above information is correct as of this date: _____

Signature of Physician _____

Please print Physician's name _____

Address: _____

Telephone:_____

*******Please attach a copy of the child's shot record*******