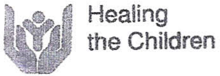

Medical Screening Record/LOCAL PROGRAM

To be completed by referring medical professional or social services provider.

CHILD'S NAME:

SEX: _____ BIRTHDATE: _____ HEIGHT: _____ WEIGHT: _____

IMMUNIZATIONS: IF YES, FOR WHAT, WHEN

ALLERGIES

DIAGNOSIS: PRIMARY

DIAGNOSIS: SECONDARY

HOW CONFIRMED

CURRENT VITAL SIGNS

PRESCRIPTION: MEDICATIONS CURRENTLY BEING TAKEN

PAST MEDICAL HISTORY & PAST SURGERIES OF PATIENT
(Date and Type)

PAST MEDICAL HISTORY OF PARENTS AND SIBLINGS
(Date and Type)

Completed By: ______________________________ Date: ____________________

HTC 201 (REV 7/90)