



Child's Medical Record
St. Francis of Assisi School
 525 Holley Street, St. Albans, WV 25177
 Phone: (304) 727-5690 Fax: (304) 727-5690

CHILD'S NAME _____ BIRTHDATE _____
 ADDRESS _____
 PARENT'S NAME _____
 DENTIST'S NAME _____ DATE OF LAST DENTAL EXAM _____

Appearance at Examination: Height _____ Weight: _____
 Head:
 Eyes:
 Nose:
 Throat: Adenoids: Tonsils:
 Teeth:
 Lungs:
 Heart:
 Abdomen:
 Extremities:
 Genitalia:
 Congenital Malformations:

Previous Illnesses:	
Measles _____	Other Illnesses or Medications
Mumps _____	(List):
Chickenpox _____	_____
Pneumonia _____	_____
Colds _____	_____
Convulsions _____	_____
Rheumatic Fever _____	_____

Habits and Behavior:	Allergies:
Sleeping _____	(List):
Eating _____	_____
Eliminating _____	_____
Thumb Sucking _____	Injuries:
Nail Biting _____	_____

Physician's Signature

Date