Clyde Austin 4-H Center
Environmental Education Program
Health Record

Child's Name _____
Age _____ Date of Birth _____ Sex _____
Height _____ Weight _____ Last Tetanus Immunization_____
Has your child had any of the following illnesses or symptoms?
Please circle those that apply and explain below, including date and illness.

1. Symptoms: epilepsy, convulsions, dizziness, paralysis, loss of consciousness
2. Diseases of the heart, blood vessels, high blood pressure
3. Diseases of the lungs, asthma, pain in the chest, persistent cough, shortness of breath, spitting blood
4. Stomach or intestinal trouble: ulcers, gall bladder, liver disorder, jaundice, hernia, enteritis, nervous stomach
5. Arthritis, rheumatic fever, goiter, strained, pulled or weak muscles
6. Diabetes, kidney or bladder disease
7. Hay fever or allergies (state specific insect allergies)
8. Impaired vision and/or hearing or chronic ear infections
9. Skin rashes or disease
10. Allergies to medicine (state specific medicinal allergies)
11. Sleeping problems
12. Currently taking medication
13. Under care of a physician

Explanation for any of the above circled items:

_____
_____
_____

Other pertinent information:

_____
_____
_____