

Department of Education STUDENT'S HEALTH RECORD

Student Address Label

Name _____ (Last) _____ (First) _____ (Middle Initial)

Female Preschool: Entry Date ____ / ____ / ____
 Male Elementary: Entry Date ____ / ____ / ____
 Intermediate/Middle: Entry Date ____ / ____ / ____
 High: Entry Date ____ / ____ / ____

Birthdate

Month	Day	Year				

Parent's Name _____ (Mother/Guardian) _____ (Father/Guardian)

Allergies: _____

Please complete the following sections (CHECK IF YES)

MEDICAL STATUS											
Allergy (type) <input type="checkbox"/>	Cancer/Leukemia <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Seizures <input type="checkbox"/>	Vision Problem <input type="checkbox"/>						
Asthma <input type="checkbox"/>	Chronic Cough/Wheezing <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	JRA Arthritis <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>							
Behavioral Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Rheumatic Heart <input type="checkbox"/>	Skin Problems <input type="checkbox"/>							

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) (See Results Below)	Provider's Signature	Provider's Stamp or Printed Name
						R.	L.	R.	L.																		
__ / __ / __																											
__ / __ / __																											

TUBERCULOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)			
Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic
__ / __ / __	__ / __ / __		
__ / __ / __	__ / __ / __		

CHEST X-RAY		
Date	Results	Location

DENTAL EXAMINATION	
Dental Check-Up	Date
	__ / __ / __

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)							
DTaP, DTP, DT, Tdap or Td	Type	Date	Date	Date	Date	Date	Date
		__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Polio (IPV or OPV)	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Hib (<i>Haemophilus influenzae</i> type b)	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Pneumococcal Conjugate	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Hepatitis B	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
MMR	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	Varicella	__ / __ / __
Hepatitis A	Date	__ / __ / __	__ / __ / __				
Other	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Other	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __

*OFFICE USE ONLY (Rev. 2010)

Physician, APRN, PA or Clinic _____

Health History Comments: Include Referrals and Reports. Recommendation for significant findings.

(Please Print)

Date		Signature & Title	Date		Signature & Title