

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/Legal Guardian) (Father/Legal 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) <small>See Results Below</small>	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	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Polio (IPV or OPV)	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Hib (Haemophilus influenzae 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 _____

