Department of Education

# Student's Health Record

Student Address Label

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

Female ❑ Male ❑

Preschool: Entry Date __/__/__
Elementary: Entry Date __/__/__
Intermediate/Middle: Entry Date __/__/__
High: Entry Date __/__/__

Birthdate ☐☐ ☐☐ ☐☐
Month Day Year

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

Please complete the following sections **(CHECK IF YES)**

## Medical Status

| | | | |
|---|---|---|---|
| Allergy (type) ❑ | Cancer/Leukemia ❑ | Hearing Problems ❑ | Rheumatic Heart ❑ |
| Asthma ❑ | Chronic Cough/Wheezing ❑ | Heart Disease ❑ | Sickle Cell Anemia ❑ |
| Vision Problems ❑ | Diabetes ❑ | Hemophilia ❑ | Seizures ❑ |

## Physician's Examination Code: N-Normal; A-Abnormal; C-Corrected; R-Receiving Care

| Date | Grade | Height | Weight | BMI | Blood Pressure | Vision R. | Vision L. | Hearing R. | Hearing L. | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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## Tuberculosis Examination
### Mantoux Test (Intradermal)

| Date Given | Date Read | Results (mm) | Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above) |
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## Chest X-Ray

| Date | Results | Location |
|---|---|---|
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## Dental Examination

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| Dental Check-Up | / / |

## Immunizations (Vaccines, Dates Given: Month/Day/Year)

| DTaP, DTP, DT, or Td | | Polio (IPV or OPV) | | HIB Haemophilus influenzae type B | | Hepatitis B | Pneumoccal (Prevnar) | MMR |
|---|---|---|---|---|---|---|---|---|
| Type | Date Given | Type | Date Given | Type | Date Given | Date Given | Date Given | Date Given |
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| | / / | | / / | | / / | / / | / / | / / |
| | / / | OTHER | | | | | | Varicella |
| Hep A* | | Type | Date Given | Date Given | Date Given | | | / / |
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| | / / | | / / | / / | / / | | | Measles |
| | | | | | | | | / / |
| | | | | | | | | Mumps |
| | | | | | | | | / / |
| | | | | | | | | Rubella |
| | | | | | | | | / / |

Physician, APRN, PA or Clinic _____
**(Signature or stamp if different from above)**

* in future, will be required

***OFFICE USE ONLY** (Rev. 2009)

**Health History Comments:** Include Referrals and Reports. Recommendation for significant findings.
(Please Print)

| Date | | Signature & Title | Date | | Signature & Title |
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