

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) (See Results Below)	Provider's Signature	Provider's Stamp or Printed Name	
						R.	L.	R.	L.																			

TUBERCULOSIS EVALUATION		
Check one box below, complete date assessment, test or x-ray was administered.		Physician, APRN, PA, Clinic
Negative TB Risk Assessment	Date: ____ / ____ / ____	
Negative test for TB infection	Date: ____ / ____ / ____	
Positive test, and negative chest x-ray	Date: ____ / ____ / ____	

DENTAL EXAMINATION	
Dental Check-Up	Date: ____ / ____ / ____
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 (<i>Haemophilus influenzae</i> type b)	Type						
	Date						
Pneumococcal Conjugate	Type						
	Date						
Hepatitis B	Type						
	Date						
Hepatitis A	Type						
	Date						
MMR	Type						
	Date						
HPV	Type						
	Date						
Other	Type						
	Date						

Physician, APRN, PA or Clinic _____

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

(Please Print)

Date		Signature & Title	Date		Signature & Title