

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 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)

Vaccine	Type	Dates Given (M/D/Y)						
	DTaP, DTP, DT, Tdap or Td	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 _____

