Department of Education

STUDENT'S HEALTH RECORD

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

Female ❑ Male ❑

Preschool: Entry Date __/__/__

Elementary: Entry Date __/__/__

Intermediate/Middle: Entry Date __/__/__

High: Entry Date __/__/__

Student Address Label

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	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	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
__/__/__																							__/__/__				
__/__/__																							__/__/__				
__/__/__																							__/__/__				
__/__/__																							__/__/__				

TUBERCULOSIS EXAMINATION

MANTOUX TEST (INTRADERMAL)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)	Y *	N
__/__/__	__/__/__			❑	❑
__/__/__	__/__/__			❑	❑
__/__/__	__/__/__			❑	❑

CHEST X-RAY

Date	Results	Location		
			❑	❑
			❑	❑

DENTAL EXAMINATION

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	Varicella	MMR	Y *	N
Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given		
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	DTaP	❑ ❑
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	Polio	❑ ❑
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	HIB	❑ ❑
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	HEP	❑ ❑
	__/__/__	OTHER						Measles	MMR	❑ ❑
	__/__/__	Type	Date Given	Date Given	Date Given			__/__/__	Varicella	❑ ❑
	__/__/__		__/__/__	__/__/__	__/__/__			Mumps		
	__/__/__		__/__/__	__/__/__	__/__/__			__/__/__		
	__/__/__		__/__/__	__/__/__	__/__/__			Rubella		
								__/__/__		

Physician, APRN, PA or Clinic _____

(Signature or stamp if different from above)

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