

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/Guardian) (Father/Guardian)

 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"/>	Rheumatic Heart <input type="checkbox"/>				
Asthma <input type="checkbox"/>	Chronic Cough/Wheezing <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>				
Vision Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Seizures <input type="checkbox"/>				

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE																													
Date	Grade	Height	Weight	Blood Pressure	Vision		Hearing		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		
					R.	L.	R.	L.																					
__/__/__																													
__/__/__																													
__/__/__																													
__/__/__																													

TUBERCULOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)				Y * N
Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)	
__/__/__	__/__/__			<input type="checkbox"/> <input type="checkbox"/>
__/__/__	__/__/__			<input type="checkbox"/> <input type="checkbox"/>
__/__/__	__/__/__			<input type="checkbox"/> <input type="checkbox"/>
CHEST X-RAY				Y * N
Date	Results	Location		
				<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
DENTAL EXAMINATION				Y * N
Dental Check-Up				
				<input type="checkbox"/> <input type="checkbox"/>

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)										Y * N
DTaP, DTP, DT, or Td		Polio (IPV or OPV)		HIB <i>Haemophilus influenzae</i> type B		Hepatitis B	Varicella	MMR		
Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given		
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	DTaP <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	Polio <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	HIB <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	HEP <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	MMR <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	MMR <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	Measles <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__	Type	Date Given	Date Given	Date Given	OTHER			Varicella <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	Mumps <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	Rubella <input type="checkbox"/> <input type="checkbox"/>	
	__/__/__		__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		

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

*OFFICE USE ONLY (Rev. 2002)

