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)

Allergies: _____

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

MEDICAL STATUS

Allergy (type) ❑	Cancer/Leukemia ❑	Hearing Problems ❑	Hypertension ❑	Seizures ❑	Vision Problem ❑
Asthma ❑	Chronic Cough/Wheezing ❑	Heart Disease ❑	JRA Arthritis ❑	Sickle Cell Anemia ❑	
Behavioral Problems ❑	Diabetes ❑	Hemophilia ❑	Rheumatic Heart ❑	Skin Problems ❑	

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
___/___/___																											
___/___/___																											

TUBERCULOSIS EXAMINATION
MANTOUX TEST (INTRADERMAL)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic
___/___/___	___/___/___		
___/___/___	___/___/___		

CHEST X-RAY

Date	Results	Location

DENTAL EXAMINATION

Dental Check-Up	___/___/___

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DTaP, DTP, DT, Tdap or Td	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio (IPV or OPV)	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib (*Haemophilus influenzae* type b)	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Pneumococcal Conjugate	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hepatitis B	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
MMR	Date	___/___/___	___/___/___	___/___/___	**Varicella**	___/___/___	___/___/___
Hepatitis A	Date	___/___/___	___/___/___				
Other	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Other	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Physician, APRN, PA or Clinic _____

***OFFICE USE ONLY** (Rev. 2010)