Department of Education

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)

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	
	___/___/___		___/___/___		___/___/___	___/___/___	___/___/___	___/___/___	MMR	
	___/___/___	OTHER						Measles		
	___/___/___	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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