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 Type | DTaP, DTP, DT, or Td Date Given | Polio (IPV or OPV) Type | Polio (IPV or OPV) Date Given | HIB *Haemophilus influenzae* type B Type | HIB *Haemophilus influenzae* type B Date Given | Hepatitis B Date Given | Varicella Date Given | MMR Date Given |
|---|---|---|---|---|---|---|---|---|
| | __/__/__ | | __/__/__ | | __/__/__ | __/__/__ | __/__/__ | __/__/__ |
| | __/__/__ | | __/__/__ | | __/__/__ | __/__/__ | __/__/__ | __/__/__ |
| | __/__/__ | | __/__/__ | | __/__/__ | __/__/__ | __/__/__ | __/__/__ |
| | __/__/__ | | __/__/__ | | __/__/__ | __/__/__ | __/__/__ | __/__/__ |
| | __/__/__ | OTHER | | | | | | Measles __/__/__ |
| | __/__/__ | Type | Date Given | | Date Given | | Date Given | Mumps __/__/__ |
| | __/__/__ | | __/__/__ | | __/__/__ | | __/__/__ | Rubella __/__/__ |

| Y* | N | |
|---|---|---|
| ❑ | ❑ | DTaP |
| ❑ | ❑ | Polio |
| ❑ | ❑ | HIB |
| ❑ | ❑ | HEP |
| ❑ | ❑ | MMR |
| ❑ | ❑ | Varicella |

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

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