

# 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/Legal Guardian) \_\_\_\_\_ (Father/Legal Guardian)

Allergies: \_\_\_\_\_

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"/> | Hypertension <input type="checkbox"/>    | Seizures <input type="checkbox"/>           | Vision Problem <input type="checkbox"/> |
| Asthma <input type="checkbox"/>              | Chronic Cough/Wheezing <input type="checkbox"/> | Heart Disease <input type="checkbox"/>    | JRA Arthritis <input type="checkbox"/>   | Sickle Cell Anemia <input type="checkbox"/> |   |
| Behavioral Problems <input type="checkbox"/> | Diabetes <input type="checkbox"/>               | Hemophilia <input type="checkbox"/>       | Rheumatic Heart <input type="checkbox"/> | Skin Problems <input type="checkbox"/>      |   |

### PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

| Date | Grade | Height | Weight | BMI | Blood Pressure | Vision |    | Hearing |    | 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) <small>See Results Below</small> | Provider's Signature | Provider's Stamp or Printed Name |  |
|------|-------|--------|--------|-----|----------------|--------|----|---------|----|------|------|------|--------|-------|-------|-------|---------|----------------|------|-----------|-------------|-----------|--|---|---|----------------------|----------------------------------|--|
|      |       |        |        |     |                | R.     | L. | R.      | L. |      |      |      |        |       |       |       |         |                |      |           |             |           |  |   |   |                      |                                  |  |
| / /  |       |        |        |     |                |        |    |         |    |      |      |      |        |       |       |       |         |                |      |           |             |           |  |   |   |                      |                                  |  |
| / /  |       |        |        |     |                |        |    |         |    |      |      |      |        |       |       |       |         |                |      |           |             |           |  |   |   |                      |                                  |  |

### TUBERCULOSIS EVALUATION

|  |                          |                             |
|--|--------------------------|-----------------------------|
| Check one box below, complete date assessment, test or x-ray was administered. |                          | Physician, APRN, PA, Clinic |
| Negative TB Risk Assessment  | Date: ____ / ____ / ____ |                             |
| Negative test for TB infection   | Date: ____ / ____ / ____ |                             |
| Positive test, and negative chest x-ray  | Date: ____ / ____ / ____ |                             |

### DENTAL EXAMINATION

|                 |                          |
|-----------------|--------------------------|
| Dental Check-Up | Date: ____ / ____ / ____ |
| Dental Check-Up | Date: ____ / ____ / ____ |

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

|   | Type |     |     |     |     |     |     |
|---|------|-----|-----|-----|-----|-----|-----|
| DTaP, DTP, DT, Tdap or Td                   | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| Polio (IPV or OPV)                          | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| Hib ( <i>Haemophilus influenzae</i> type b) | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| Pneumococcal Conjugate                      | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| Hepatitis B                                 | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| Hepatitis A                                 | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| MMR   | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| HPV   | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |
| Other                                       | Date | / / | / / | / / | / / | / / | / / |
|   | Type |     |     |     |     |     |     |

Physician, APRN, PA or Clinic \_\_\_\_\_

