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/Legal Guardian) (Father/Legal 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		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) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
						R.	L.	R.	L.																		
__/__/__																											
__/__/__																							__/__/__				

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	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

***OFFICE USE ONLY**

Physician, APRN, PA or Clinic _____

Health History Comments: Include Referrals and Reports. Recommendation for significant findings.
(Please Print)

Date		Signature & Title	Date		Signature & Title