Department of Education

**STUDENT’S HEALTH RECORD**

- **Name**: 
  - (Last) 
  - (First) 
  - (Middle Initial)

- **Birthdate**: 
  - Month 
  - Day 
  - Year

- **Parent’s Name**: 
  - (Mother/Guardian) 
  - (Father/Guardian)

- **Student Address Label**

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

### MEDICAL STATUS

- **Allergy (type)**
  - Asthma
  - Vision Problems

- **Cancer/Leukemia**
  - Hearing Problems
  - Heart Disease
  - Sickle Cell Anemia

- **Rheumatic Heart**
  - Sickle Cell Anemia
  - Seizures

## PHYSICIAN’S EXAMINATION CODE

- **Date**
  - Grade
  - Height
  - Weight
  - Blood Pressure
  - Vision
  - Hearing
  - Ears
  - Nose
  - Throat
  - Heart
  - Lungs
  - Abdomen
  - Nervous System
  - Skin
  - Scars
  - Extremities
  - Nutrition

- **Significant Findings and Recommendations**

- **Varicella Immunity**
  - Secondary to Disease (DATE)

- **Reviewed Immunization Record**
  - *(Check if Yes)*

- **Provider’s Stamp or Printed Name**

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

- **DTaP, DTP, DT, or Td**
  - Type
  - Date Given

- **Polio (IPV or OPV)**
  - Type
  - Date Given

- **HIB Haemophilus influenzae type B**
  - Type
  - Date Given

- **Hepatitis B**
  - Type
  - Date Given

- **Varicella**
  - Type
  - Date Given

- **MMR**
  - Type
  - Date Given

- **OTHER**
  - Measles
  - Mumps
  - Varicella

- **DENTAL EXAMINATION**
  - Dental Check-Up

- **TUBERCULOSIS EXAMINATION**
  - Mantoux Test (Intradermal)
  - Date Given
  - Read Results (mm)

- **CHEST X-RAY**
  - Date
  - Results
  - Location

*OFFICE USE ONLY* (Rev. 2002)
**Health History Comments:** Include Referrals and Reports. Recommendation for significant findings.

(Please Print)

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