Department of Education

STUDENT'S HEALTH RECORD

Student Address Label

(Last) (First) (Middle Initial)

Month Day Year

Female ☐ Male ☐

Preschool: Entry Date / /
Elementary: Entry Date / /
Intermediate/Middle: Entry Date / /
High: Entry Date / /

ame (Mother/Guardian) (Father/Guardian)

plete the following sections **(CHECK IF YES)**

MEDICAL STATUS

pe)	☐	Cancer/Leukemia	☐	Hearing Problems	☐	Rheumatic Heart	☐
	☐	Chronic Cough/Wheezing	☐	Heart Disease	☐	Sickle Cell Anemia	☐
blems	☐	Diabetes	☐	Hemophilia	☐	Seizures	☐

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

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
																						/ /				
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TUBERCULOSIS EXAMINATION
MANTOUX TEST (INTRADERMAL)

Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)
/ /		
/ /		
/ /		

CHEST X-RAY

Results	Location

DENTAL EXAMINATION

eck-Up	/ /

SE ONLY (Rev. 2006)

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

Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /							/ /
Hep A*		Type	Date Given		Date Given		Date Given	/ /
	/ /		/ /		/ /		/ /	/ /
	/ /		/ /		/ /		/ /	/ /
								/ /
								/ /

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

* in future, will be required