Department of Education

Student's Health Record

Student Information

Name: _____
(Last) (First) (Middle Initial)

Sex: ☐M ☐F
DOB: ____/____/____

Entry dates
Pre-K: ____/____/____
Elem.: ____/____/____
Int./Middle: ____/____/____
High: ____/____/____

Student Address Label

Parent/Legal Guardian Names:
1. _____ 2. _____

Medical Conditions

☐Allergies	☐Asthma	☐Chronic Cough/Wheezing	☐Hearing Problems	☐Seizures	Other
☐Bees	☐Blood Disorders	☐Diabetes Type I	☐Heart Condition	☐Skin Problems	_____
☐Food	☐Bone/Joint Disorders	☐Diabetes Type II	☐High Blood Pressure	☐Vision Problems	_____
☐Medication	☐Cancer/Leukemia	☐Genetic Condition	☐Metabolic Disorder		_____

Physical Examination (N - Normal, A - Abnormal, R - Receiving Care)

Date	Height	Weight	BMI	*Blood Lead	Blood Pressure	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Provider's Signature	Printed Name
____/____/____																				
____/____/____																				

Tuberculosis Evaluation

Check appropriate box	Date
☐Negative TB Risk Assessment	____/____/____
☐Negative test for TB infection	____/____/____
☐Positive test & negative chest x-ray	____/____/____

Dental Examination

Dental Check-Up	____/____/____
Dental Check-Up	____/____/____

Vision and Hearing

Visual Acuity ☐Color Vision Deficient
R 20/____ L 20/____
☐Corrected ☐Corrected
____/____/____

Hearing Thresholds
500 1000 2000 4000
R ____|____|____|____
L ____|____|____|____
____/____/____

Signature or Stamp of Healthcare Provider or Clinic:

Immunizations

DTaP, DTP, DT or Td	Type					
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Polio (IPV or OPV)	Type					
	Date	____/____/____	____/____/____	____/____/____	____/____/____	
Hib (Haemophilus influenzae tybe b)	Type					
	Date	____/____/____	____/____/____	____/____/____	____/____/____	
Pneumococcal Conjugate	Type					
	Date	____/____/____	____/____/____	____/____/____	____/____/____	
Hepatitis B	Type				Varicella immunity secondary to disease (date)	
	Date	____/____/____	____/____/____	____/____/____		____/____/____
Hepatitis A	Type			Varicella		
	Date	____/____/____	____/____/____	Date	____/____/____	____/____/____
MMR	Type				MCV	
	Date	____/____/____	____/____/____		Date	____/____/____
HPV	Type				Tdap	
	Date	____/____/____	____/____/____	____/____/____	Date	____/____/____
Other	Type					
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Health History Comments: Include referrals and reports. Recommendation for significant findings. (Please print)

Date	Comments	Signature & Title	Date	Comments	Signature & Title

6-8A-1