STUDENT'S HEALTH RECORD Grades K-6

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

Birthdate ☐☐ ☐☐ ☐☐
Month Day Year

Grade _____

Female ❑ Male ❑

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

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 R.	Vision L.	Hearing R.	Hearing L.	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
/ /																							/ /				
/ /																							/ /				

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)

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	/ /	/ /	/ /	/ /	/ /	/ /	
Hepatitis A	Type							
	Date	/ /	/ /	/ /	/ /	/ /	/ /	
MMR	Type				**Varicella Date**			
	Date	/ /	/ /	/ /		/ /	/ /	
HPV	Type				**Meningococcal Conjugate Date**			
	Date	/ /	/ /	/ /		/ /	/ /	
Other	Type							
	Date	/ /	/ /	/ /	/ /	/ /	/ /	

Physician, APRN, PA or Clinic _____