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 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 _____

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

Date		Signature & Title	Date		Signature & Title

TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

☐ Yes ☐ No	**Does this person have significant TB symptoms?** Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following: ☐ Coughing up blood ☐ Fever ☐ Night sweats ☐ Unexplained weight loss ☐ Unusual weakness ☐ Fatigue

2. Check for TB Risk Factors

- If any "Yes" box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked "No", then TB clearance can be issued without testing

☐ Yes ☐ No	**Was this person born in a country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
☐ Yes ☐ No	**Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?**
☐ Yes ☐ No	**At any time has this person been in contact with someone with *infectious TB disease*? (Do not check "Yes" if exposed only to someone with latent TB)**
☐ Yes ☐ No	**Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?** *(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)*
☐ Yes ☐ No	**For persons under age 16 only: Is someone in the child's household from a country with an elevated TB rate?**

Provider Name with Licensure/Degree:	**Person's Name and DOB:**
Assessment Date:	**Name and Relationship of Person Providing Information (if not the above-named person):**