



STUDENT HEALTH RECORD GRADES 7-12

School Year: _____

**Required for all 7th, 9th, 11th, and 12th grade entry and all students NEW to St. Andrew's Schools.
Also required for students Grade 7-12 wanting to participate in athletics and competitive sports.**

Student Last Name: _____ First: _____ M.I.: _____ Female

Birth Date: _____ Date Entered: _____ Grade: _____

Medical Insurance Carrier: _____ Policy Number: _____

Date of Exam: _____ **Height** _____ **Weight** _____ **B/P** _____ / _____ **Pulse** _____

Normal		Describe Abnormal		Normal		Describe Abnormal	
Neurologic				Neck			
HEENT				Shoulders			
Heart				Arms/Hands			
Lungs				Hips/Thighs			
Abdomen				Knees			
Skin				Feet/Ankles			

Past medical history of: _____

*Physical Exam TO BE COMPLETED BY A U.S. LICENSED PRACTITIONER (MD, DO, PA or APRN) Initial _____

Vision Screening	Auditory Screening	Postural
Type: <u>Right</u> <u>Left</u>	Type: <u>Right</u> <u>Left</u>	<input type="checkbox"/> No spinal abnormality
With correction <u>20/</u> <u>20/</u>	<u>Pass</u> <u>Pass</u>	<input type="checkbox"/> Spinal abnormality:
Without correction <u>20/</u> <u>20/</u>	<u>Fail</u> <u>Fail</u>	<u>Mild</u> <u>Moderate</u> <u>Marked</u>
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made

Health Conditions:

Allergies None Yes*(please list): _____

Asthma No Yes*(circle one) *Intermittent* *Mild* *Moderate* *Severe* *Exercise Induced* *Cold Induced*

Diabetes No Yes*(circle one): *Type I* *Type II*

Behavioral/Psych/Social No Yes*(please list): _____

Seizures No Yes*(please list type): _____

Other _____

*Please attach action plan for all conditions.

Physical Activity:

This student:

MAY participate fully in school program/PE/athletics and competitive sports

MAY participate with the following RESTRICTIONS _____

MAY NOT participate in school program PE athletics and competitive sports

Medications:

Daily: _____ PRN: _____

IMMUNIZATIONS: Up to date New student **MUST ATTACH IMMUNIZATION RECORD** Tetanus updated and charted below

DTaP,		Other		Other	
Type	Date	Type	Date	Type	Date

Tuberculosis Evaluation

Check one box below; complete date assessment, test or x-ray was administered.			Physician, APRN, PA, Clinic
<input type="checkbox"/> Negative TB Risk Assessment	Date:	/ /	
<input type="checkbox"/> Negative test for TB infection	Date:	/ /	
<input type="checkbox"/> Positive test, and negative chest x-ray	Date:	/ /	

I hereby certify that I am the treating provider, have examined this student and confirm that the information on this form is truthful, complete and accurate.

Signature of U.S. Licensed Practitioner (MD, DO, PA or APRN) Date Signed Printed/Stamped Name and Phone Number



IMMUNIZATION RECORD GRADES 7-12

School Year: _____

**All students new to St. Andrews Schools must provide a record of childhood immunizations.
Physicians: You may print a copy of the immunization record or complete and sign this form.**

Student Name:				Birth Date:		
DTP, DTaP, DT or Td		Polio: OPV or IPV		MMR	Hepatitis B	Hepatitis A
Type	Date	Type	Date	Date	Date	Date
1		1		1	1	1
2		2		2	2	2
3		3			3	
4		4				
5						
Varicella			Meningitis	HPV	Other	
Date			Date	Date	Type	Date
1	2		1	1		
Immunity secondary to illness: date of illness _____				2	2	
Practitioner's Signature _____					3	

Immunization Requirements

The following requirements are in compliance with Hawaii State Law. Documentation of immunity by serologic testing signed by practitioner is acceptable. Age, spacing of immunizations, exemptions and exceptions to these requirements will be evaluated as per the rules set forth in the Hawaii Administrative Rules, Title 11, Chapter 157.

Childcare or Preschool	Kindergarten - Grade 12	Grade 7
Diphtheria-Tetanus-Pertussis (DTaP)	Diphtheria-Tetanus-Pertussis (DTaP)	Human Papillomavirus (HPV)
<i>Haemophilus influenzae</i> type b (Hib)	Hepatitis A (Hep A)	Meningococcal Conjugate (MCV)
Hepatitis A (Hep A)	Hepatitis B (Hep B)	Tetanus-diphtheria-pertussis (Tdap)
Hepatitis B (Hep B)	Human Papillomavirus (HPV)*	
Measles-Mumps-Rubella (MMR)	Meningococcal Conjugate (MCV)*	
Pneumococcal Conjugate Vaccine (PCV)	Measles-Mumps-Rubella (MMR)	
Polio (IPV)	Polio (IPV)	
Varicella (chickenpox)	Tetanus-diphtheria-pertussis (Tdap)*	
	Varicella (chickenpox)	

*All students must show evidence of receiving these immunizations prior to attendance in 7th grade or higher.

Physician: I hereby certify that the above information has been reviewed and is accurate to the best of my knowledge.

Signature of U.S. Licensed Practitioner (MD, DO, PA, APRN)

DATE

PRINT/STAMP AND PHONE NUMBER