MID-PACIFIC INSTITUTE STUDENT HEALTH RECORD

Mid-Pacific Institute ◊ 2445 Ka`ala St. ◊ Honolulu, HI 96822

Damon Hall: Phone: (808) 973-5000 ◊ MS / HS Health Room: Phone: (808) 973-5120 ◊ES Health Room: Phone: (808) 441-3807

THIS DOCUMENT HAS BEEN REVISED: Effective immediately completed forms must be submitted through MAGNUS only.

A) STUDENT INFORMATION

Name: _____ **Gender:** ☐ MALE ☐ FEMALE **Date of Birth:** _____
(Last) (First) (Middle Initial) (MM/DD/YY)

Medical Insurance: _____ **Policy No.** _____

B) MEDICAL STATUS: Please complete the following sections (Check if YES)

Allergy (Type): _____ _____ _____	☐	Cancer/Leukemia:	☐	Hemophillia:	☐	**Comments:** _____
		Chronic Cough/Wheezing:	☐	Rheumatic Heart:	☐	
		Diabetes:	☐	Sickle Cell Anemia:	☐	**Significant Past Illness, Injury, or Allergy:** _____
		Hearing Problems:	☐	Seizures	☐	
Asthma:	☐	Heart Disease:	☐	Vision Problems:	☐	

C) PHYSICIAN'S EXAMINATION CODE: N = Normal; A = Abnormal; C = Corrected; R = Receiving Care

Date	Grade	Height	Weight	Blood Pressure	Vision (R./L.)	Hearing (R./L.)	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous Sys.	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 Above	Provider's Signature	Provider's Stamp or Printed Name
/ /					/	/															/ /				

D) TUBERCULOSIS EXAMINATION
Mantoux Test (Intradermal)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if different from above)
/ /	/ /		
/ /	/ /		
/ /	/ /		

CHEST X-RAY

Date	Results	Location
/ /		
/ /		

E) IMMUNIZATIONS (VACCINES, DATES GIVEN: Month/Day/Year)

DTaP, DTP, DT, or TD		Polio (IPV or OPV)		HIB *Haemophilus Influenzae* Type B		Hepatitis B	Varicella	MMR
Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given
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	/ /		/ /		/ /	/ /	/ /	/ /
	/ /	OTHER				Hepatitis A		MEASLES
	/ /	Type	Date Given		Date Given	Date Given		/ /
	/ /		/ /		/ /	/ /		MUMPS
	/ /							/ /
	/ /		/ /		/ /	/ /		RUBELLA
	/ /							/ /

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

F) ATHLETICS / DANCE CLASS (REQUIRED - TO BE UPDATED ANNUALLY)

Physician: ***I certify that I have on this date examined and found this student able and fit for participation in (CHECK IF YES):*** ***ALL SPORTS*** ☐

Baseball ☐	Bowling ☐	Cheerleading ☐	Dance ☐	Golf ☐	Kayaking ☐	Sailing ☐	Softball ☐	Swimming ☐	Track & Field ☐	Water Polo ☐
Basketball ☐	Canoe Paddling ☐	Cross Country ☐	Football ☐	Judo ☐	Precision Air Riflery ☐	Soccer ☐	Sporter Air Riflery ☐	Tennis ☐	Volleyball ☐	Wrestling ☐

Restrictions: _____ ***Physician Initials:*** _____ ***Parent Signature (required if any restrictions listed):*** _____

PLEASE ATTACH ADDITIONAL DOCUMENTATION / COMMENTS AS NEEDED

Rev. 04/24/20