HEALTH RECORD

SCHOOL:_____
GRADE:_____

NAME:_____ **SEX: MALE**_____ **FEMALE**_____

ADDRESS:_____ **DATE OF BIRTH:** _____

IMMUNIZATION, BOOSTER, & TEST DATES

DPT_____
DPT Booster_____
Tetanus Booster_____
Polio Vaccine_____
_____
MMR _____
Measles _____
Mumps _____
Rubella_____
Tuberculin Test: Mantoux_____Tine_____
Result_____
HIB_____
Hep. B. _____
Varicella Vaccine _____
Meningitis _____
Pneumococcal _____
Hep. A_____
Lead Level _____

DISEASE HISTORY

Allergies _____
_____
Asthma _____
Chickenpox _____
Meningitis _____
Tonsillitis _____
Strep Throat _____
Mononucleosis _____
Otitis Media _____
Measles _____
German Measles _____
Rubella _____
Mumps _____
Scarlet Fever _____
Pneumonia _____
Rheumatic Fever _____
Tuberculosis _____
Any chronic illness _____
_____
Emotional or Psychological Problems? _____
_____
Surgeries (Operations) _____
_____
Current Medications _____

PHYSICAL EXAMINATION

DATE OF EXAM_____

Height _____Weight _____
Blood Pressure _____
General Appearance _____
Skin_____
Eyes _____
Ears_____
Nose _____
Mouth _____
Throat _____
Glands _____
Heart _____
Hernia (males) _____
Lungs _____
Abdomen _____
Orthopedic _____
Posture _____
Spine (SCOLIOSIS) _____
Feet & Limbs _____
Hemoglobin _____
Urinalysis _____

VISION SCREENING

Without Glasses R 20/_____ L 20/_____
With Glasses R 20/_____ L 20/_____

HEARING SCREENING

Audiometric R_____ L_____

SPEECH:_____

COMMENTS:_____
_____
_____
_____
_____
_____
_____

_____ _____
Physician's Signature Date
Please stamp form with Physician's office stamp.