MID-PACIFIC STUDENT HEALTH RECORD

2445 Ka`ala St. ◊ Honolulu, HI 96822

Middle & High School Health Room (808) 973-5120 ◊ Preschool & Elementary Health Room (808) 441-3807

Please submit completed forms through MAGNUS HEALTH 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:	☐
____________	☐	Chronic Cough/Wheezing:	☐	Rheumatic Heart:	☐
____________		Diabetes:	☐	Sickle Cell Anemia:	☐
____________		Hearing Problems:	☐	Seizures:	☐
Asthma:	☐	Heart Disease:	☐	Vision Problems:	☐

Comments: ____

Significant Past Illness, Injury, or Allergy: ____

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	Reviewed Immunization Record (Check if YES)	Provider's Signature	Provider's stamp or Printed Name
/ /					/	/																	

D) TUBERCULOSIS (TB) CLEARANCE

Date	Check appropriate box (Only ONE)
/ /	☐ Negative TB risk assessment
/ /	☐ Negative Tuberculin Mantoux skin test (TST)
/ /	☐ Positive test for TB infection AND Negative chest X-ray
Interferon-Gamma Release Assays: (for 5 years and older only)	
/ /	☐ Negative QuantiFERON-TB Gold-in-Tube test (QFT-GIT)
/ /	☐ Negative T-SPOT test

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

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

IMMUNIZATIONS REQUIRED BY GRADE 7

Type	Date Given	Date Given
Human Papillomavirus HPV	/ /	/ /
Meningococcal MCV	/ /	/ /
Tetanus, Diphtheria, Pertussis Tdap	/ /	

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. 01/31/24