



Health Record

Instructions: Please complete the top line and have your child's health care provider complete the remainder.

Student Name: _____ **Sex:** M F **Date of Birth:** _____ **Grade:** _____

Date of physical: _____ **Height:** _____ **Weight:** _____ **BP:** _____

Screenings:

Vision: R: 20/_____ L: 20/_____ Both: 20/_____ Corrected? Y / N
Hearing: R_____ dcb L_____ dcb **Scoliosis:** Positive_____ Negative_____

Physical Exam WNL? Yes _____ No _____

Abnormalities: _____

This child may participate fully in school activities including physical education.

Restrictions: _____

Medical Conditions (please list and describe):

- **Allergies** (please attach care plan): _____

- **Chronic Conditions** (for asthma, please attach care plan): _____

- **Disease History:** _____

- **Surgical History:** _____
- **Psychiatric/Behavioral Issues:** _____

- **Medications:** _____

Please record the date of all immunizations. Alternatively, you may attach a separate immunization record.

VACCINES	1 st dose	2 nd dose	3 rd dose	4 th dose	5 th dose		
DTap (Td, DT)							
Tdap						Document single antigen vaccine receipt, serology titers, or varicella disease history	
IPV (Polio)						Hep B	Date: Titer:
MMR						Varicella	Date: Titer:
HIB						Measles	Date: Titer:
Hep B						Mumps	Date: Titer:
Varicella						Rubella	Date: Titer:
Pneumococcal Conjugate							
Meningococcal							
Hep A							
HPV							
Rotovirus							
Most Recent Flu:							
Other							

Please circle appropriately if the nurse may administer the following medications (with parental approval);

Acetaminophen/Ibuprofen	Liquid/chewable per age/weight Q4/Q6 PRN headache, pain	Yes	NO
Tums	1-2 tablets as needed for indigestion	Yes	NO

***PHYSICIAN'S SIGNATURE:** _____ **DATE:** _____