

STUDENT HEALTH RECORD

Student's Name _____ Grade _____

Date of Birth _____ Birthplace _____

Parent/Guardian _____

Home Phone () _____ Work/ Cell _____

Full Address _____

Previous School Attended _____

EMERGENCY PHONE NUMBERS

Father Business _____

Mother Business _____

Other _____ Cell Phone _____

EXAMINATION

Date of Exam _____

1. Height _____ Weight _____ BP _____ Eyes: R _____ L _____

2. List physical or emotional disabilities (include speech, hearing, vision)

3. Birth or Acquired Abnormalities:

4. Chronic Disorders: Diseases of heart, lung, digestive system, nervous system, urinary tract, blood, etc.

5. Specific Disorders: List if student has ever had: asthma, sickle cell disease, hemophilia, hernia, enlarged spleen, diabetes, convulsions, high blood pressure.

6. Health Aids: List if student wears eyeglasses, contact lenses, hearing aids, braces.

7. Scoliosis Exam: Negative _____ Positive _____

8. Should Activities be limited for any reason? _____

9. Can student participate in sports? If no, please explain _____

10. Injuries? (Dates) _____

11. Operations? (Dates) _____

12. Allergies? (List) _____

13. Medications: list all prescription medications taken regularly: e.g. insulin, inhalers, tablets, capsules, injections, etc.

14. Immunizations Required by New Jersey State Law: please be sure to include: month/day/year for each immunization.

DTaP/DTP #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Td _____ or Tdap _____

IPV #1 _____ #2 _____ #3 _____ #4 _____

MMR #1 _____ #2 _____ Menactra _____

Chicken Pox Disease _____ or Vaccine _____ Influenza _____

HIB #1 _____ #2 _____ #3 _____ #4 _____

Hepatitis B #1 _____ #2 _____ #3 _____

PCV #1 _____ #2 _____ #3 _____ #4 _____

Mantoux Test: Date given: _____ site: _____ (if applicable)

Date read: Negative _____ Positive _____

Physician Signature & stamp

Date
Of Exam

Office Number