Student Health Record

Student Name: _____ DOB: _____ Student Number: _____

IMMUNIZATIONS History:

Up-to-Date for a age: (boosters) ☐4-6 yr ☐Td ☐Hep B
Conscientious/Religious Objectors: (Indicate notarized copy each year)

PK	K	1	2	3	4	5	6	7	8	9	10	11	12

HEALTH History/Problems:

Allergies: _____

Significant Illness/Dates: _____

Significant Injuries/Dates: _____

Operations/Hospitalizations: _____

Current Medication: _____

IEP: _____ IHP: _____

504: _____

HEALTH SCREENS:

Vision (R/L)	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=
Hearing (R/L)	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=	R= L=
Height														
Weight														
Blood Pressure														
Month Year	Pre-K _____ _____	K _____ _____	1st _____ _____	2nd _____ _____	3rd _____ _____	4th _____ _____	5th _____ _____	6th _____ _____	7th _____ _____	8th _____ _____	9th _____ _____	10th _____ _____	11th _____ _____	12th _____ _____

NOTES:			
DATE:	Comments:	DATE:	Comments: