School Health Record for _____ _____

Student First Name Last Name

Gender: male / female DOB: mm/dd/yy ___/___/___

Does the student have a history of:

	YES	NO	Date
asthma			
diabetes			
heart disorder			
meningitis			
urinary disorder			
tuberculosis			
TB in family			
epilepsy			
fainting spells			
scoliosis in family			

other illnesses–

_____

_____

_____

_____

Allergies

Medications taking

Immunizations

DPT/DT						
Polio						
Measles						
Mumps						
Rubella						
Hepatitis A						
Hepatitis B						
Tetanus						

Tuberculin Tests
Date _____ Result _____
Date _____ Result _____

Date	G R	Height	Weight	Vision				Teeth	Hearing		Observations & Comments
				without glasses		with glasses					
				R	L	R	L		R	L	