**Page 1 of 4**

**QUICK REFERENCE:**

Physical Exam: K/1 6  11

Dental Exam: K/1 3 7

**Exemption(s) on file**:

Medical

Dental

**ALLERGIES:**

**Epi-Pen prescribed**

Date cleared to self-carry: \_\_\_\_\_\_\_\_

 

**Bureau of Community Health Systems**

**Division of School Health**

## SCHOOL HEALTH RECORD

|  |  |  |
| --- | --- | --- |
| NAME: LAST, FIRST, MIDDLE | BIRTHDATE: MONTH, DAY, YEAR | GENDER: MALE [ ]   FEMALE [ ]  |
| FATHER’S NAME: LAST, FIRST, MIDDLE Legal Guardian Custodial  | MOTHER’S NAME: LAST, FIRST, MIDDLE Legal Guardian Custodial  |
| PERSON WITH WHOM STUDENT LIVES IF DIFFERENT FROM ABOVE NAME AND RELATIONSHIP Legal Guardian Custodial  |

|  |  |  |  |
| --- | --- | --- | --- |
| **SCHOOL** **YEAR** | **SCHOOL** | **DISTRICT** | **COUNTY** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SCH YR |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| GRADE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **SPECIAL HEALTH PROBLEMS/PARENT CONCERNS:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Page 2 of 4 |  |  |  |  |
| IMMUNIZATION HISTORY |  |  |  |  |
| **VACCINE** | **DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization** |
| Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT | 1 | 2 | 3 | 4 | 5 |
| Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td | 1 | 2 | 3 | 4 | 5 |
| Polio  Type: OPV or IPV | 1 | 2 | 3 | 4 | 5 |
| Hepatitis B (HepB) | 1 | 2 | 3 | 4 | 5 |
| Measles/Mumps/Rubella (MMR) | 1 | 2 | 3 | 4 | 5 |
| Mumps disease diagnosed by physician [ ]  | Date:\_\_\_\_\_\_\_\_\_\_ |
| Varicella: Vaccine [ ]  Disease [ ]   | 1 | 2 | 3 | 4 | 5 |
| Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella  | 1 | 2 | 3 | 4 | 5 |
| Meningococcal Conjugate Vaccine (MCV4) | 1 | 2 | 3 | 4 | 5 |
| Human Papilloma Virus (HPV) Type: HPV2 or HPV4  | 1 | 2 | 3 | 4 | 5 |
| Influenza  Type: TIV (injected) LAIV (nasal) | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 |
| Haemophilus Influenzae Type b (Hib) | 1 | 2 | 3 | 4 | 5 |
| Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13 | 1 | 2 | 3 | 4 | 5 |
| Hepatitis A (HepA) | 1 | 2 | 3 | 4 | 5 |
| Rotavirus | 1 | 2 | 3 | 4 | 5 |
| **Other Vaccines: (Type and Date)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **IMMUNIZATION EXEMPTION(S) on file:**  Medical [ ]  Religious/Philosophical [ ]  Date Rescinded\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **VISION SCREENING** |  |
| **Date** | **Grade** | **Annual** | **Grade 1** | **Grade 1 or 2** | **Corrective****Lenses worn during screening** | **Referral** | **Signature (Screener)** |
| **Near** **Visual Acuity** | **Far** **Visual Acuity** | **Convex (Plus) Lens** | **Color Vision** | **Depth Perception** | **Date referred** | **Date referral completed** |
| **R** | **L** | **R** | **L** | **pass** | **fail** | **pass** | **fail** | **pass** | **fail** | **Yes** | **No** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Page 3 of 4** |  |  |  |  |  |
| **DIAGNOSTIC TESTING** i.e. TB Tests, Blood Tests, X-Ray etc. |  |
| **Test** | **Date** | **Result** | **Test** | **Date** | **Result** | **Test** | **Date** | **Result** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SCOLIOSIS SCREENING** |  |  |  |  |  |
| **Date** | **Grade** | **pass** | **fail** | **Previously****diagnosed** | **Signature (Screener)** | **Date rescreened** | **pass** | **fail** | **Date referred** | **Date referral completed** | **Signature (Re-screener)** |
|  | **6****Screened**  |  |  |  |  |  |  |  |  |  |  |
| **6th grade physical**  | (6th grade physical may be used in place of 6th grade screen) |
|  | **7** |  |  |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Page 4 of 4** |  |  |
| **HEARING SCREENING** |  |  |
|  | **INDICATE DECIBEL (DB) LEVEL FOR EACH FREQUENCY FAILED** | **mandated for grades K, 1, 2, 3, 7, 11 and****annually for ungraded special education** |
| **Date** | **Grade** | **Right Ear** | **Left Ear** | **Results** | **Referral** | **Signature (Screener)** |
| **250** | **500** | **1000** | **2000** | **4000** | **8000** | **250** | **500** | **1000** | **2000** | **4000** | **8000** | **pass** | **fail** | **Date referred** | **Date referral completed** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **GROWTH SCREENING** |
| **ANNUAL** |
| **Date** | **Grade** | **Height** | **Weight** | **BMI** | **BMI%** | **Date of notification to parent/guardian** | **Signature (Screener)** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |