



# Health Record

## Confidential

Date:

1. Enter or correct the information below.

Last Name	<input type="text"/>	First Name	<input type="text"/>	Sex	<input type="checkbox"/>
Birthdate	<input type="text"/>	Parent/ Guardian	<input type="text"/>		
Birthplace	<input type="text"/>	Address	<input type="text"/>		
Blood Group	<input type="text"/>	Home Tel.	<input type="text"/>	Cell.	<input type="text"/>
Family Dr	<input type="text"/>	Work Tel.	<input type="text"/>	Work Tel.	<input type="text"/>
Dr.'s tel.	<input type="text"/>				

## Health History

2. Enter an approximate date of illness (if known).

	Date		Date		Dates
Measles	<input type="text"/>	Scarlet Fever	<input type="text"/>	Ear aches	<input type="text"/>
Chicken Pox	<input type="text"/>	Hepatitis A	<input type="text"/>	Allergies	<input type="text"/>
Whooping Cough	<input type="text"/>	Hepatitis B	<input type="text"/>	Other	<input type="text"/>
Mumps	<input type="text"/>				

3. Enter date of immunization vaccinations and boosters. Attach copies of vaccination certificates not already submitted.

	Dates					Dates
DPT/DT series	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Rubella	<input type="text"/>
Polio series	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Measles vacc.	<input type="text"/>
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Mumps vacc.	<input type="text"/>
Meningitis	<input type="text"/>					

4. Enter medications and reason(s) for prescription:

Medications	Reason
<input type="text"/>	<input type="text"/>

5. Enter hospitalizations/surgical treatments/professional counseling or therapy:

Condition	Doctor	Treatment Date(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Fill in information if available.

Vision Test		Date	<input type="text"/>
Visual acuity/Right eye	<input type="text"/>	Visual acuity/Left eye	<input type="text"/>
Conclusions	<input type="text"/>		
Hearing Test		Date	<input type="text"/>
Right ear	<input type="text"/>	Left ear	<input type="text"/>
Conclusions	<input type="text"/>		

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I have read the above medical information and history and have no changes to make.*

**PHYSICAL EXAMINATION**

**(To be filled out by a licensed Physician)**

**School Year 2007/8**

Full name of student: .....

Sex: ..... Date of birth: .....

Height .....

Weight .....

Eyes .....

Ears .....

Nose .....

Throat .....

Heart .....

Lungs .....

Abdomen .....

Hernia .....

Extremities .....

Posture (spine) .....

Skin .....

Menstrual History .....

General appraisal .....

Recommendations and Restrictions.....

I hereby certify that the student.....does not show signs or symptoms of infectious diseases and is fit for school attendance.

Si certifica che l'alunno/a ....., visitato da me in data odierna, non presenta segni o sintomi di malattie infettive e puo' frequentare la scuola.

Examining Physician/ Medico esaminatore .....

Address/Indirizzo .....

Tel. ....

Date .....