Parker School
Student's Health Record

REQUIRED FOR:
- **NEW STUDENTS**
- **7TH GRADERS**

Name ______________________ (Last) ______________________ (First) ______________________ (Middle Initial)

Female ❑
Male ❑

Preschool: Entry Date __/__/__
Elementary: Entry Date __/__/__
Intermediate/Middle: Entry Date __/__/__
High: Entry Date __/__/__

Birthdate [ ][ ] [ ][ ] [ ][ ][ ][ ]
Month Day Year

Parent's Name ______________________ (Mother/Legal Guardian) ______________________ (Father/Legal Guardian)

Allergies: ______________________

Please complete the following sections **(CHECK IF YES)**

Medical Status

Allergy (type) ❑	Cancer/Leukemia ❑	Hearing Problems ❑	Hypertension ❑	Seizures ❑	Vision Problem ❑
Asthma ❑	Chronic Cough/Wheezing ❑	Heart Disease ❑	JRA Arthritis ❑	Sickle Cell Anemia ❑	
Behavioral Problems ❑	Diabetes ❑	Hemophilia ❑	Rheumatic Heart ❑	Skin Problems ❑	

Physician's Examination Code: N-Normal; A-Abnormal; C-Corrected; R-Receiving Care

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
/ /																							/ /				
/ /																							/ /				

Tuberculosis Evaluation

Check one box below, complete date assessment, test or x-ray was administered.			Physician, APRN, PA,Clinic
	Negative TB Risk Assessment	Date: / /	
	Negative test for TB infection	Date: / /	
	Positive test, and negative chest x-ray	Date: / /	

Dental Examination

Dental Check-Up	Date: / /
Dental Check-Up	Date: / /

Immunizations (Vaccines, Dates Given: Month/Day/Year)

Vaccine							
DTaP, DTP, DT, Tdap or Td	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Polio (IPV or OPV)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hib *(Haemophilus influenzae* type b)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Pneumococcal Conjugate	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis A	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
MMR	Type				**Varicella**		
	Date	/ /	/ /	/ /	**Date**	/ /	/ /
HPV	Type				**Meningococcal Conjugate**		
	Date	/ /	/ /	/ /	**Date**	/ /	/ /
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /

Physician, APRN, PA or Clinic ______________________

Excellence | Integrity | Compassion

65-1224 Lindsey Road
Kamuela, HI 96743
Ph: 808-885-7933

Health History Comments: Include Referrals and Reports. Recommendation for significant findings.
(Please Print)

Date		Signature & Title	Date		Signature & Title