

La Pietra - Hawaii School for Girls STUDENT'S HEALTH RECORD

Name _____
(Last) (First) (Middle Initial)

Female
 Male

Elementary: _____
 Intermediate/Middle: _____
 High: _____

Entry Date ____/____/____
 Entry Date ____/____/____
 Entry Date ____/____/____

Birthdate

Month			Day		Year				

Parent's Name _____
(Mother/Guardian) (Father/Guardian)

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

MEDICAL STATUS			
Allergy (type) <input type="checkbox"/>	Cancer/Leukemia <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Rheumatic Heart <input type="checkbox"/>
Asthma <input type="checkbox"/>	Chronic Cough/Wheezing <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>
Vision Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Seizures <input type="checkbox"/>

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	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	
					R.	L.	R.	L.																				
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TUBERCULOSIS EXAMINATION MANTOUX

TEST (INTRADERMAL)			
Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)
/ /	/ /		
/ /	/ /		
/ /	/ /		

CHEST X-RAY

Date	Results	Location

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DtaP, DTP, DT, or Td		Polio (IPV or OPV)		HIB Haemophilus Influenzae type B		Hepatitis B	Varicella	MMR
		Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /	OTHER						Measles
	/ /	Type	Date Given	Date Given	Date Given			Mumps
	/ /		/ /	/ /	/ /	/ /	/ /	Rubella
	/ /		/ /	/ /	/ /	/ /	/ /	