



20__ - 20__

SCHOOL HEALTH RECORD

School: _____

Student Name: _____

Birthdate: _____

Immunizations: Required by Law to attend school

DPT _____ 5th dose required if 4th dose given before age 4
 Polio _____ 4th dose required if 3rd dose given before age 4
 MMR _____ 2nd dose required
 Hepatitis B _____ 3 doses, K - 6
 Varicella (chickenpox) _____ 1 dose required for Kindergarten effective Fall 2006
 Hib _____ Pre-K only; 3 or 4 doses 0-14 months, 1 dose if 15 months or older
 TB Test _____ Result: Neg _____ or Pos _____
 Other _____

Developmental History:

Please give the approximate age at which this child:
 walked alone _____ was toilet trained _____ spoke in sentences _____ dressed self _____
 How does this child's development compare to other children, such as his/her brothers/sisters or playmates?
 about the same _____ delayed _____ advanced _____

Health Conditions: Please check any that this child has had

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Concerns about relationships | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Behavior/Emotional concerns | <input type="checkbox"/> Ear problems/Poor hearing | <input type="checkbox"/> Meningitis/Encephalitis |
| <input type="checkbox"/> Birth/Congenital malformations | <input type="checkbox"/> Eczema/Skin conditions | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Blood problems | <input type="checkbox"/> Eye problems/Poor vision | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Bone/Joint problems | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Toothaches/Dental problems |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Wetting during day or night |

Injuries, Illnesses & Hospitalizations: Please explain

