CONCORD COMMUNITY SCHOOLS
Health Record

STUDENT NAME: _____ DATE OF BIRTH: ____/_____/_____

SCHOOL: _____ GRADE: _____ DATE: _____

PARENT OR GUARDIAN: _____ PHONE: (_____)_____

ADDRESS: _____

If student has any of the following conditions, explain briefly:
Bleeding Disorder_____
Hearing Loss_____
Speech Defect_____
Seizure Disorder_____
Asthma_____
Rheumatic Fever_____
Diabetes_____
Allergies_____
Other_____
Takes medication regularly? If so, name these_____
Have any serious illnesses, accidents, or surgeries caused any impairment? YES or NO
If yes, what_____

I give permission for this medical information to be shared with appropriate school staff to ensure my child's safety and to best meet his/her health needs.

_____
Signature of Parent or Guardian

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IMMUNIZATIONS*:* TO BE FILLED OUT BY DOCTOR'S OFFICE, DOCUMENT MONTH, DAY, AND YEAR

	#1 m/d/y	#2 m/d/y	#3 m/d/y	#4 m/d/y	#5 m/d/y	#6 m/d/y	NEXT APPT M/D/Y
DPT/DTaP	/ /	/ /	/ /	/ /	/ /	/ /	/ /
DT	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Polio/IPV	/ /	/ /	/ /	/ /	/ /	/ /	/ /

	#1 m/d/y	Booster m/d/y	Disease Confirmed By Physician				
M.M.R. *or* MEASLES	/ /	/ /	History of Disease mo.	yr.	Doctor's Name	Sickle Cell Anemia Date_____ *(Must be reported, if done)*	Results_____
	/ /	/ /				Lead Poisoning Date_____ *(Must be reported, if done)*	Results_____
RUBELLA	/ /	/ /					
MUMPS	/ /	/ /					

TB SKIN TESTS: Date_____ Pos._____ Neg._____ Verified by:_____
Varicella Vaccine: #1_____ #2_____ Disease_____/_____/_____
Hep B: Date#1_____#2_____#3_____ Hep A: Date #1_____#2_____

DOCTOR'S EXAMINATION

CODE: No defect = 0 If defect, note condition.

_____
(Patient's Name)

Eyes_____

Visual Acuity R_____L_____
Wears Glasses _____
Referred to eye specialist_____

Height_____
Weight_____
Blood Pressure_____

Nose _____
Throat _____
Heart _____
Lungs _____
Skin _____
Glands: Lymph_____

Ears_____

Hearing (gross)_____

Urinalysis_____
Hemoglobin_____
or Hematocrit_____

Abdomen_____
Hernia_____
Reflexes_____
Genitalia_____
Orthopedic_____

Physically fit to participate in a physical education program? YES _____ NO _____
Competitive Sports? YES _____ NO _____

Restrictions? YES or NO (circle one)
Please explain: _____

_____

Date of Exam: _____ Office Phone: _____ Physician's Signature: _____

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DENTAL EXAMINATION

CODE: No defect = 0 If defect, note condition.

Teeth _____
Para-oral Structure _____
Infection _____
Abnormalities _____

Is further treatment necessary? Immediate Care_____ Routine Care_____ NO_____

Have arrangements been made for further treatment? YES_____ NO_____

COMMENTS:_____

_____

Date: _____ Phone: _____ Dentist's Signature: _____