STUDENT HEALTH RECORD
GRADES 7-12
School Year: _____

Required for all 7th grade entry and all students NEW to St. Andrews Schools.
Also required for students Grade 7-12 wanting to participate in athletics and competitive sports.

Student Last Name:_____First:_____M.I.:_____ □Male □Female

Birth Date:_____Date Entered:_____Grade: _____

Medical Insurance Carrier:_____ Policy Number:_____

Date of Exam:_____Height_____Weight_____B/P_____/_____Pulse _____

	Normal	Describe Abnormal		Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
Heart			Arms/Hands		
Lungs			Hips/Thighs		
Abdomen			Knees		
Skin			Feet/Ankles		
Past medical history of:					

***Physical Exam TO BE COMPLETED BY A U.S. LICENSED PRACTITIONER (MD, DO, PA or APRN) Initial_____**

Vision Screening

Type:	Right	Left
With correction	20/	20/
Without correction	20/	20/

□ Referral made

Auditory Screening

Type:	Right	Left
	Pass	*Pass*
	Fail	*Fail*

□ Referral made

Postural

□ No spinal abnormality
□ Spinal abnormality:
Mild *Moderate* *Marked*
□ Referral made

Health Conditions:

Allergies □None □Yes*(please list):_____
Asthma □ No □ Yes*(circle one) *Intermittent* *Mild* *Moderate* *Severe* *Exercise Induced* *Cold Induced*
Diabetes □ No □ Yes*(circle one): *Type I* *Type II*
Behavioral/Psych/Social □No □Yes*(please list):_____
Seizures □No □Yes*(please list type):_____
Other_____

***Please attach action plan for all conditions.**

Physical Activity:

This student:

□MAY participate fully in school program/PE/athletics and competitive sports
□ MAY participate with the following RESTRICTIONS_____
□ MAY NOT participate in □school program □PE □athletics and competitive sports

Medications:

Daily:_____PRN: _____

IMMUNIZATIONS: □Up to date □ New student **MUST ATTACH IMMUNIZATION RECORD** □Tetanus updated and charted below

DTaP,		Other		Other	
Type	Date	Type	Date	Type	Date

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: / /	

I hereby certify that I am the treating provider, have examined this student and confirm that the information on this form is truthful. complete and accurate.

Signature of U.S. Licensed Practitioner (MD, DO, PA or APRN) **Date Signed** **Printed/Stamped Name and Phone Number**

IMMUNIZATION RECORD
GRADES 7-12
School Year: _____

All students new to St. Andrews Schools must provide a record of childhood immunizations. Physicians: You may either print a copy of the child's immunization record or complete and sign this form.

Student Name:					**Birth Date:**	
DTP, DTaP, DT or Td		**Polio: OPV or IPV**		**MMR**	**Hepatitis B**	**Hepatitis A**
Type	Date	Type	Date	Date	Date	Date
1		1		1	1	1
2		2		2	2	2
3		3			3	
4		4				
5						
Varicella			**Meningitis**	**HPV**	**Other**	
Date			Date	Date	Type	Date
1	2		1	1		
Immunity secondary to illness: date of illness _____			2	2		
Practitioner's Signature _____				3		

Immunization Requirements

The following requirements are in compliance with Hawaii State Law. Documentation of immunity by serologic testing signed by practitioner is acceptable. Age, spacing of immunizations, exemptions and exceptions to these requirements will be evaluated as per the rules set forth in the Hawaii Administrative Rules, Title 11, Chapter 157.

Childcare or Preschool	**Kindergarten – Grade 12**	**Grade 7**
Diphtheria-Tetanus-Pertussis (DTaP)	Diphtheria-Tetanus-Pertussis (DTaP)	Human Papillomavirus (HPV)
Haemophilus influenzae type b (Hib)	Hepatitis A (Hep A)	Meningococcal Conjugate (MCV)
Hepatitis A (Hep A)	Hepatitis B (Hep B)	Tetanus-diphtheria-pertussis (Tdap)
Hepatitis B (Hep B)	Human Papillomavirus (HPV)*	
Measles-Mumps-Rubella (MMR)	Meningococcal Conjugate (MCV)*	
Pneumococcal Conjugate Vaccine (PCV)	Measles-Mumps-Rubella (MMR)	
Polio (IPV)	Polio (IPV)	
Varicella (chickenpox)	Tetanus-diphtheria-pertussis (Tdap)*	
	Varicella (chickenpox)	

*All students must show evidence of receiving these immunizations prior to attendance in 7th grade or higher.

Physician: I hereby certify that the above information has been reviewed and is accurate to the best of my knowledge.

_____ _____ _____

Signature of U.S. Licensed Practitioner (MD, DO, PA, APRN) DATE PRINT/STAMP AND PHONE NUMBER