STUDENT HEALTH RECORD

A) STUDENT INFORMATION

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

Birthdate | | | | | | | | | | |

Gender: ☐ MALE ☐ FEMALE

REQUIRED BY LAW

Medical Insurance: _____

Policy Number: _____

St. Andrew's Schools
224 Queen Emma Square
Honolulu, HI 96813

B) MEDICAL STATUS: PLEASE COMPLETE THE FOLLOWING SECTIONS (CHECK IF YES)

Allergy (type)	❑	Chronic Cough/Wheezing	❑	Heart Disease	❑	Sickle Cell Anemia	❑	Comments:
Asthma	❑	Diabetes	❑	Hemophilia	❑	Seizures	❑	Significant Past Illness, Injury, or Allergy:
Cancer/Leukemia	❑	Hearing Problems	❑	Rheumatic Heart	❑	Vision Problems	❑	

C) 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)	PPD Screening (Check if Yes) See Results	Provider's Signature	Provider's Stamp or Printed Name
					R	L	R	L																			
/ /																							/ /				
/ /																							/ /				

D) TUBERCULOSIS EXAMINATION

MANTOUX TEST (INTRADERMAL)				CHEST X-RAY		
Date Given	Date Read	Results (mm)	Physician, APRN, PA or Clinic (Signature or Stamp if Different from Above)	Date	Results	Location
/ /	/ /			/ /		
/ /	/ /			/ /		

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

DTaP, DTP, DT, or Td		Polio (IPV or OPV)		HIB Haemophilus influenzae type B		Hepatitis B	Hepatitis A	MMR
Type	Date given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /	**Measles**	/ /	**OTHER**				
Varicella				Type	Date Given	Date Given	Date Given	
Type	Date given							
	/ /	**Mumps**			/ /	/ /	/ /	
	/ /		/ /		/ /	/ /	/ /	
	/ /	**Rubella**			/ /	/ /	/ /	
	/ /		/ /		/ /	/ /	/ /	

Physician, APRN, PA or Clinic (Signature or Stamp if different from above)

F) ATHLETICS (REQUIRED – TO BE UPDATED ANNUALLY)

Physician: I certify that I have, on this date, examined and found this student able and fit for participation in (CHECK IF YES): ALL SPORTS ❑

Baseball	❑	Basketball	❑
Bowling	❑	Canoe Paddling	❑
Cheerleading	❑	Cross Country	❑
Football	❑	Golf	❑
Judo	❑	Kayaking	❑
Precision Air Riflery	❑	Sailing	❑
Soccer	❑	Softball	❑
Sporter Air Riflery	❑	Swimming	❑
Tennis	❑	Track and Field	❑
Volleyball	❑	Water Polo	❑
Wrestling	❑		

Restrictions:	Physician's Initial:
Parent Initial (Required if any restrictions are listed)	Date: