St. Joseph School-School Health Record

Name_____ Date of Birth_____ Father's name_____ Mother's Name_____ .
Last First MI

Address_____ Guardian_____ Allergies_____ .

Phone Number _____ Chronic Ilness/Special Needs: _____ .

Date																	Chicken Pox Disease:	Date
School																		
Grade																	(See back for medical information)	
Age																	**IMMUNIZATIONS**	
SCREENINGS																	DTP/DTp/	1.
Vision	Date																DT/Td	2.
Glasses	(Y/N)																	3.
Near Vision	Right																	4.
	Left																	5.
Dist. Vision	Right																Tdap	6.
	Left																	
Hearing	Date																Menactra/MCV4	
Screening	Right																	
	Left																Polio	1.
Physical Exam																		2.
Height																		3.
Weight																		4.
Blood Pressure																		
Teeth																	Hepatitis B	1.
Eyes																		2.
Ears																		3.
Nose																		
Throat																	Hepatitis A	1.
Chest																		2.
Heart																		
Hernia																	MMR	1.
Extremities																		2.
Posture/Scoliosis																		
Physical Education																	Varicella	1.
Nurse's Initials																		2.

Physician Name & Phone:	Hib	Prevnar
	1.	1.
	2.	2.
Dentist Name & Phone:	3.	3.
	4.	4.
Nurse's Initials/Signature:		
	HPV	1.
		2.
		3.
	Flu/H1N1	
Codes: 0 = No Defect CB = Color Blind Testing R = Referral Sent W = Watch	TB Test	