Pin #_____

School_____

HOWELL TOWNSHIP PUBLIC SCHOOLS STUDENT HEALTH RECORD

Child's Name:_____ Date:_____

Parent's Name:_____ Phone: _____

Address:_____ D.O.B.:_____

Name of Family Physician:_____ Phone:_____

IMMUNIZATION RECORD (MONTH, DAY, YEAR AS REQUIRED BY LAW)

VACCINE TYPE	DISEASE DATE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	Mo/Day/Yr
DIPTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, Indicate in corner box)*							
Tdap							
Polio – Inactivated Polio Vaccine (IPV) If oral vaccine, indicate (OPV) in corner box							
MEASLES, MUMPS, RUBELLA (MMR)							
MEASLES					Measles Serology	Date	Titer:
MUMPS					Rubella Serology	Date	Titer:
RUBELLA					Mumps Serology	Date	Titer:
HAEMOPHLUS B (HIB)							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL CONJUGATE							
MENINGOCOCCAL							
HEPATITIS A							
INFLUENZA VACCINE							
OTHER							

Tuberculin Test (Mantoux):_____ (as required)

Date Given:_____ Date Read:_____ Results:_____

Is child receiving any medication? __Yes __No Name of Medication:_____

MEDICAL HISTORY

Asthma_____ Allergies_____ Chickenpox_____ Pneumonia_____ Operations_____

Major Injuries_____ Lyme Disease_____ Mononucleosis_____ Encephalitis_____ Meningitis_____

Rheumatic Fever_____ Head Injury_____ Other_____ Diabetes_____ Seizure Disorder_____

Major Sensory Defect_____ Does child wear glasses?_____ Explain:_____

PHYSICAL APPRAISAL

Height_____ Weight_____ B/P_____ Heart_____ Eyes_____ Ears_____ Lungs_____

Glands_____ Nose_____ Throat_____ Tonsils_____ Thyroid_____ Lymph Glands_____ Hernia_____

Abdomen_____ Nutrition_____ Scoliosis_____ (10 years and up)

Physician's Comments:_____

Physician's Signature:_____ Date of Physical Exam:_____

(stamps are not accepted)

Physician's Name:_____ Phone:_____

(please print)

(Revised 10/14)

PHYSICIAN'S STAMP