

St. Albert The Great School  
STUDENT HEALTH RECORD  
HEALTH SERVICES-STUDENT SERVICES

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PARENTS: Complete Section I

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SECTION I: Date \_\_\_\_\_

Student's Name \_\_\_\_\_

Address \_\_\_\_\_

Student's Birth Date \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Name of Parent (s) or Guardian \_\_\_\_\_

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Check the disease (s) that your child has or has had:

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ ADD \_\_\_\_\_ ADHD \_\_\_\_\_

Heart Disease \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Cancer \_\_\_\_\_ Tuberculosis \_\_\_\_\_

Seizure Disorder \_\_\_\_\_ Other \_\_\_\_\_

Does your child take any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Please name medication and reason it's taken \_\_\_\_\_

Does student have a physical disability and/or limitation? Yes \_\_\_\_\_ No \_\_\_\_\_

List allergies: \_\_\_\_\_

Would you say the student is (check one) very active \_\_\_\_\_ average \_\_\_\_\_ quiet \_\_\_\_\_

Please state any health problems the student may have that would be important for the school to know:

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EXAMINING DENTIST: Complete Section II

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SECTION II: Date of Examination \_\_\_\_\_

1. At this time, child has no apparent dental defects \_\_\_\_\_
2. Child is under regular dental care \_\_\_\_\_
3. Appointments have been made for correction of dental defects \_\_\_\_\_

\_\_\_\_\_  
Dentist's Signature

(Have physician complete other side)

STUDENT'S NAME: \_\_\_\_\_

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**EXAMINING PHYSICIAN: Complete Section III**

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1. At this time, child has no apparent physical limitations. (check) \_\_\_\_\_

2. Prior history and present examination shows child has physical condition(s) and /or limitations(s) as listed below to which school personnel should be alerted: (describe condition and/or degree of limitations)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Comments: \_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATION RECORD: (To be completed by physician/clinic) Day/month/year is required for each dose**

DPT (DTaP, DT, Td) Dates

\_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ 5<sup>th</sup>

Polio Date (Specify OPV or IPV)

OPV

\_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ 5<sup>th</sup>

IPV

\_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ 5<sup>th</sup>

MMR

\_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> HIB \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup>

Hepatitis B

\_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup>

Chicken Pox \_\_\_\_\_

Mantoux PPD \_\_\_\_\_

Negative \_\_\_\_\_ Positive \_\_\_\_\_

Date of Examination \_\_\_\_\_

\_\_\_\_\_  
Physician or Clinic Signature