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_______

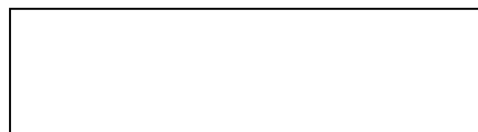
Glands_____ Nose______ Throat______ Tonsils______ Thyroid______ Lymph Glands______ Hernia______

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)



PHYSICIAN'S STAMP

(Revised 10/14)