

Department of Education  
**STUDENT'S HEALTH RECORD**

HONOLULU WALDORF SCHOOL  
FAX: (808) 373-2040

PARENT: I hereby give my consent to my child's health care provider to share my child's health information with school personnel.

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial)

Female  Preschool: Entry Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Male  Elementary: Entry Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Intermediate/Middle: Entry Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 High: Entry Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Birthdate 

Month	Day	Year					

Parent's Name \_\_\_\_\_ (Mother/Guardian) \_\_\_\_\_ (Father/Guardian)

Allergies: \_\_\_\_\_

Please complete the following sections **(CHECK IF YES)**

MEDICAL STATUS									
Allergy (type) <input type="checkbox"/>	Cancer/Leukemia <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Seizures <input type="checkbox"/>	Vision Problem <input type="checkbox"/>				
Asthma <input type="checkbox"/>	Chronic Cough/Wheezing <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	JRA Arthritis <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>					
Behavioral Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Rheumatic Heart <input type="checkbox"/>	Skin Problems <input type="checkbox"/>					

**PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE**

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) <small>See Results Below</small>	Provider's Signature	Provider's Stamp or Printed Name
						R.	L.	R.	L.																		
__ / __ / __																											
__ / __ / __																											

TUBERCULOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)			
Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic
__ / __ / __	__ / __ / __		
__ / __ / __	__ / __ / __		

CHEST X-RAY		
Date	Results	Location

DENTAL EXAMINATION	
Dental Check-Up	__ / __ / __

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)							
<b>DTaP, DTP, DT, Tdap or Td</b>	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
<b>Polio (IPV or OPV)</b>	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
<b>Hib (<i>Haemophilus influenzae</i> type b)</b>	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
<b>Pneumococcal Conjugate</b>	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
<b>Hepatitis B</b>	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
<b>MMR</b>	Date	__ / __ / __	__ / __ / __	__ / __ / __	Varicella	__ / __ / __	__ / __ / __
<b>Hepatitis A</b>	Date	__ / __ / __	__ / __ / __				
<b>Other</b>	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
<b>Other</b>	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __

\*OFFICE USE ONLY (Rev. 2010)

Physician, APRN, PA or Clinic \_\_\_\_\_

