Student Health Record

Name _____
Health Alert _____
Birthdate _____

IMMUNIZATIONS		ORAL ASSESSMENT			
Type	**Date (Month/Day/Year)**	**Date**	**Findings**	**Referral Date**	**Services Received**
DtaP DPT or DT					
Td					
Polio					
MMR					
Hepatitis B					
Varicella					
HIB (prior to age 5 only)					
Other					

HEARING SCREENING

		Audiometry Results (Pass/Fail)		Other Tests (Specify)			Action Taken Date
Grade	**Date**	**Right**	**Left**	**Right**	**Left**	**Referral Date**	**(Aid,Seating,T/A,Tubes,etc.)**

VISION SCREENING

		Distance Acuity		Lenses	Referral	Date / Action Taken
Grade	**Date**	**Right**	**Left**	**(Type)**	**Date**	**(Lenses, Surgery, etc.)**