Mid-Pacific Institute
2445 Kaala Street, Honolulu, Hawaii 96822

STUDENT'S HEALTH RECORD

Female ❑ Preschool: Entry Date ___/___/___

Male ❑ Elementary: Entry Date ___/___/___

Intermediate/Middle: Entry Date ___/___/___

High: Entry Date ___/___/___

Mailing Address:

Name _____
(Last) (First) (Middle Initial)

Birthdate ___ ___ ___ ___ ___ ___ ___ ___
Month Day Year

Parent's Name _____ (Mother/Guardian) _____ (Father/Guardian)

MEDICAL STATUS: Please complete the following sections (Check if YES)

Allergy (Type)	❑	Cancer/Leukemia	❑	Hearing Problems	❑	Rheumatic Heart	❑
Asthma	❑	Chronic Cough/Wheezing	❑	Heart Disease	❑	Sickle Cell Anemia	❑
Vision Problems	❑	Diabetes	❑	Hemophilia	❑	Seizures	❑

PHYSICIAN'S EXAMINATION CODE: N = Normal; A = Abnormal; C = Corrected; R = Receiving Care

Date	Grade	Height	Weight	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous Sys.	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	Varicella Immunity Secondary to Disease (Date)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
					R.	L.	R.	L.																			
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				
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TUBERCULOSIS EXAMINATION
Mantoux Test (Intradermal)

Date Given	Date Read	Results (mm)	Physician, APRN, PA or Clinic (Signature or Stamp if different from above)	Y*	N
/ /				❑	❑
/ /				❑	❑
/ /				❑	❑

CHEST X-RAY

Date	Results	Location	Y*	N
			❑	❑
			❑	❑

DENTAL EXAMINATION

		Y*	N
Dental Check-Up	/ /	❑	❑

IMMUNIZATIONS (VACCINES, DATES GIVEN: Month/Day/Year)

DTaP, DTP, DT or Td		Polio (IPV or OPV)		HIB *Haemophilus Influenzae* Type B		Hepatitis B	Varicella	MMR
Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /	OTHER						MEASLES
	/ /	Type	Date Given	Date Given		Date Given		/ /
	/ /							MUMPS
	/ /		/ /	/ /		/ /		/ /
	/ /		/ /	/ /		/ /		RUBELLA
								/ /

	Y*	N
DTap	❑	❑
Polio	❑	❑
HIB	❑	❑
HEP	❑	❑
MMR	❑	❑
Varicella	❑	❑

Physician, APRN, PA or Clinic _____
(Signature or Stamp if different from above)

*OFFICE USE ONLY (Rev. 2002)