

NEW BREMEN SCHOOL HEALTH RECORD

Student's Name _____ Date _____
Address _____ Birthdate _____
Father's or Guardian's Name _____ Phone _____
Physician's Name _____
Physician's Address _____ Phone _____

FAMILY HISTORY

Have you of your immediate family had any of the following illnesses: Tuberculosis () Diabetes ()
Rheumatic Fever () Epilepsy () Cancer () Mental Illness ()
Other significant illnesses _____

Speech, Hearing, Visual Handicaps _____

PAST HISTORY OF CHILD (GIVE DATES)

Chicken Pox _____	Diphtheria _____
Whooping Cough _____	German Measles (3 Day) _____
Scarlet Fever _____	Measles _____
Tonsillitis _____	Rheumatic Fever _____
Poliomyelitis _____	Nephritis _____
Mumps _____	Convulsions _____
Ear Infections _____	Heart Disease _____
Defects (Club foot, etc.) _____	
Tuberculosis _____	Diabetes _____
Other serious illnesses (Types and Dates) _____	

Hospitalizations _____

Allergies (Hives, Asthma, Hay Fever, Eczema, Medications) _____

Physical or Personality Characteristics that would be helpful to the teacher in understanding student _____

RECORD OF IMMUNIZATIONS AND TESTS (GIVE DATES)

DPT	#1 _____	#2 _____	#3 _____	#4 _____	#5 _____
Oral Polio	#1 _____	#2 _____	#3 _____	#4 _____	
MMR	#1 _____	#2 _____			
Hepatitis B	#1 _____	#2 _____	#3 _____		
HIB	#1 _____	#2 _____	#3 _____	#4 _____	
TB Skin Test	_____				
X-Ray	_____				
Others (Specify)	_____				

PHYSICAL EXAMINATION

DATE _____ HEIGHT _____ WEIGHT _____

VISION _____ R _____ L _____ HEARING _____ R _____ L _____

SPEECH _____

POSTURE _____

EYES _____

EARS _____

NOSE _____

THROAT AND TONSILS _____

TEETH _____

HEART _____

LUNGS _____

ABDOMEN _____

HERNIA _____

BLOOD PRESSURE _____

EXTREMITIES _____

FEET _____