Date of physical exam & TB must be after Aug 4, 2014

Forms due by April 30, 2015

Confidential

New Student Gr. 4 & 6

KAMEHAMEHA SCHOOLS HAWAII

Student Health Record - 2015 / 2016

Name (Last)	(First)	(MI)	Sex M F	Birthdate:

Address	City	Island	Zip	Grade:

Parent To Complete This Section

Student Medical History (Please answer all questions)

1. Has your child had any allergic reactions to medications, foods, beestings, etc.? Yes _____ No _____
2. If yes, what was the reaction to? When was the last reaction? What kind of reaction? (hives? difficulty breathing? etc)

   _____

   How was she/he treated? _____
3. List significant medical conditions (ie. asthma, diabetes, etc), major illnesses or injuries: _____

   _____
4. List all medications taken regularly (for asthma, acne, allergies, etc.): _____

   _____

I certify that the above information is true and correct to the best of my knowledge.

Print Parent Name	Parent's Signature	Date

Physician To Complete This Section

Immunizations Required For School Attendance

(Month/day/year are required by State Law)

TB Clearance
Neg PPD within last 12 mos. or
Pos PPD = CXR within 6 yrs.

DTap/DTP	/ /	/ /	/ /	/ /	/ /	Td/Tdap		/ /	Date Given / By	/ /	
Polio	/ /	/ /	/ /	/ /		MMR	/ /	/ /	Date Read / By	/ /	
Hep B	/ /	/ /	/ /	/ /	Other		/ /	/ /	Results		mm
Varicella vaccination dates		/ /	/ /		Varicella Disease			/ /			

Physical Examination Results			N	A		N	A		N	A
Height	ins.	Ears			Heart			Skin		
Weight	lbs.	Eyes			Lungs			Genitalia		
Pulse		Nose			Abdomen			Extremities		
Blood Pressure		Mouth			Nervous System			Spine/Scoliosis		
		Throat			Vision Screening			Hearing Screening		

N = Normal A = Abnormal

Does this child have any allergies to medications, foods, beestings, etc.? **Yes** _____ **No** ____

Please describe reaction, treatment, etc. _____

Is student able to participate in vigorous physical education, intramurals and other school activities? **Yes**____ **No**____

Please list conditions that require restriction or limitation of activities: _____

_____

I certify that the student's TB examination, physical examination and immunizations are documented according to the requirements in the Hawaii Administrative Rules, chapter 11 - 157.

Healthcare Provider's Name (please print/stamp)	Healthcare Provider's Signature	Date of Exam

Rev.09/13