



STUDENT'S PERMANENT HEALTH RECORD

1. PERSONAL DATA			Birthday		ID Number			
Name (Last) _____ (First) _____ (Nickname) _____			Mo. _____	Day _____	Yr. _____	(Pencil Only)		
Sex M F	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other		Parent or Guardian: Name: _____					
Address: (pencil only)			Phone: Home _____		Work _____			
			(pencil only) () _____		() _____			
2. HEALTH STATUS DATA: List significant health problems (e.g. developmental or physical disabilities, seizure disorders, allergies, diabetes, etc.)			8. SPECIAL HEALTH CONSIDERATIONS (e.g. hearing aids, emergency medical plan, medications, etc.) (pencil only)					

3. VISION SCREENING										9. IMMUNIZATIONS Record of Immunizations – Enter date of each dose – Mo/Day/Year Important: Please refer to the box below for assistance in recording immunizations.																																																																																																																																																																																													
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