ENR-09B Student Health Record for Hanalani Schools

Grades 4-12

Name_____ Birthdate___/___/___ ❑ Male ❑ Female Exam Performed on___/___/___
(Legal Last Name) (Legal First Name) (Middle Initial)

Height_____ Weight_____ BMI_____ BP___/___ Pulse_____ Medical Insurance Coverage_____

Physical Exam TO BE COMPLETED BY A U.S. LICENSED PRACTITIONER (MD, DO, PA, or APRN) ON THIS FORM

	Normal	Describe Abnormal		Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
Heart			Arms/Hands		
Lungs			Hips		
Abdomen			Knees		
Skin			Feet/Ankles		

Past Medical History

Vision Screening:

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral Made

Auditory Screening:

Type:	Right	Left
	Pass	Pass
	Fail	Fail

❑ Referral Made

Postural:

❑ No spine abnormality
❑ Spine abnormality:
Mild Moderate Marked
❑ Referral Made

Health Conditions: *Action plan REQUIRED for all yes answers. Action plan must be updated annually and signed by your physician.

Allergies ❑ No ❑ Yes*(circle one): Life Threatening Non-Life Threatening Seasonal Contact
Asthma ❑ No ❑ Yes*(circle one): Intermittent Mild Moderate Severe Exercise Induced Cold Induced
Diabetes ❑ No ❑ Yes*(circle one): Type I Type II
Seizures ❑ No ❑ Yes*(circle one): Epileptic Rolandic Other_____
Other Health Conditions*:_____

Physical Activity:

This student:
❑ **MAY** participate fully in school program/PE/athletics/sports
❑ **MAY NOT** participate in school program/PE/athletics/sports
❑ Has **RESTRICTIONS**, and a detailed note has been attached or previously submitted

Medications: Please list below.**

**For medications to administered at school, the parent/legal guardian must complete the Authorization to Administer Medication at School form.

Daily_____ PRN (as needed)_____

Tuberculosis (TB) Screening: REQUIRED for ALL students attending school in Hawaii for the first time.

❑ State of Hawaii TB Risk Assessment for Adults and Children (DOH TB Document F & G) completed and attached***
❑ TB skin test or chest x-ray completed and charted below

***REQUIRED FOR ALL STUDENTS THAT HAVE TRAVELED OUTSIDE THE U.S. FOR A DURATION OF 4 WEEKS OR MORE

	Date given	Date read	Results (mm)	Practitioner
Intradermal				
	Date	Results	Location	Practitioner
Chest x-ray				

Physician: I hereby certify that I have examined this student.

Signature of U.S. Licensed Practitioner (MD, DO, PA, APRN)	Date	Printed/Stamped Name and Phone Number

ENR-09B Student Health Record for Hanalani Schools

Grades 4-12

Name_____
(Legal Last Name) (Legal First Name) (Middle Initial)

Birthdate____/____/____ Division: ❑ LS (Grades 4-6) ❑ US (Grades 7-12) Grade_____ Date of Entry____/____/____

Immunization Record

If filling in this form, the form must be completed in its entirety with physician's signature.
Alternatively, you may attach the physician's immunization summary generated by your electronic medical record.

Type of Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Tetanus, Diptheria, Pertussis (DTP or DTap)	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Polio (IPV, OPV)	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	
Measles, Mumps, Rubella (MMR Combo)	MM/DD/YYYY	MM/DD/YYYY			
Hepatitis A	MM/DD/YYYY	MM/DD/YYYY			
Hepatitis B	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY		
Varicella (Chicken pox) or Chicken Pox Verified Immunity Secondary to Disease (Date)	MM/DD/YYYY	MM/DD/YYYY			
	Chicken Pox Verified Immunity Secondary to Disease (Date)				
Pheumococcal Conjugate Vaccine (PCV)	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	
Haemophilus influenzae (Hib)	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	
Tetanus-diphtheria-pertussis (Tdap)	MM/DD/YYYY				
Meningococcal Conjugate (MCV)	MM/DD/YYYY				
Human Papillomavirus (HPV)	MM/DD/YYYY	MM/DD/YYYY			

Physician: I hereby certify that the above information and/or attached documentation of the student named above has been reviewed by me and is accurate to the best of my knowledge.

Signature of U.S. Licensed Practitioner (MD, DO, PA, APRN)	Date	Printed/Stamped Name and Phone Number