

PUPIL'S HEALTH RECORD

Burriss Laboratory School

Muncie, Indiana

Student ID # _____

1. Pupil's Name _____ Parent/Guardian _____
2. Address _____ Zip _____ Telephone: Work # _____ Home # _____
3. School _____ Grade _____ Date of Birth _____ Age _____ Cell # _____
4. Illness Record: Chickenpox _____ Asthma _____ Diabetes _____ Seizures _____
- Chr. Ear Infections _____ Allergies _____ Other _____

5. Immunizations: PLEASE INCLUDE MONTH/DAY/YEAR

DPT	POLIO	MMR #1	#2	HEP B
1.		MEASLES		1.
2.		RUBELLA		2.
3.		MUMPS		3.
4.		SICKLE CELL		VARICELLA
5.		HIB		1.
Tdap		HepA 1.	2.	2.

6. TESTS: Tuberculosis-Type _____ MCV4 1. _____ 2. _____
- Sickle Cell Anemia _____
- Urinalysis _____ Sugar _____ Alb. _____
- MCT Vision _____

(This side for licensed physician)

CODE: O-Normal XX-Needs medical attention OO-Corrected

Wt. _____

Ht. _____

7. Vision: Unassisted R _____ L _____ 16. Lungs _____
- Assisted R _____ L _____ 17. Heart: Normal _____
8. Ears R _____ L _____ 18. Blood Pressure _____
- Hearing R _____ L _____ 19. Musculo-skeletal System: Normal _____
9. Skin and Scalp _____ Type of defect _____
10. Teeth _____ 20. State of Nutrition _____
11. Nose _____ 21. This pupil (should-should not) participate in athletics _____
12. Tonsils _____
13. Glands of neck _____
14. Thyroid _____
15. Abdomen _____

Signed: _____ M.D.

Address _____

ROUTINE MEDICATIONS: _____ Phone _____ Date _____

REMARKS _____