Waolani Judd Nazarene School Student Health Form

Name _____ Female ☐ Preschool: Entry Date / /
(Last) (First) (Middle Initial) Male ☐ Elementary: Entry Date / /
Middle: Entry Date / /

Birthdate / /
Month Day Year

Parent's Name _____ _____
(Mother/Guardian) (Father/Guardian)

Please complete the following sections (CHECK IF YES)

MEDICAL STATUS

Allergy (type) ☐	Cancer/Leukemia ☐	Hearing Problems ☐	Rheumatic Heart ☐
Asthma ☐	Chronic Cough/Wheezing ☐	Heart Disease ☐	Sickle Cell Anemia ☐
Vision Problems ☐	Diabetes ☐	Hemophilia ☐	Seizures ☐

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	Blood Pressure	Vision (Right)	Vision (Left)	Hearing (Right)	Hearing (Left)	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				

TUBERCULOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)

Date Given	Date Given	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different form Above)

CHEST X-RAY

Date Given	Results	Location

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DTaP, DTP, DT, or TD		Polio (IPV or OPV)		HIB Haemophilus Influenza type B		Hepatitis B	Varicella	MMR (Measles, Mumps, & Rubella)
Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		/ /	Hepatitis A	/ /	/ /
	/ /		/ /		/ /		/ /	/ /
	/ /		/ /		/ /	/ /	/ /	/ /
	/ /		/ /		HPV	/ /	Physician, APRN, PA, or Clinic	
	/ /		/ /		Date Given		(Signature or Stamp if different from above)	
					/ /			

*Office Use Only (Rev. 2025)