

HILLEL YESHIVA
Student Health History

Student Name _____ Sex: M _____ F _____

Entering Grade _____ Age _____ Date Of Birth _____

Name Of Physician _____

**to be completed by a physician or nurse practitioner* Record of Immunizations
(Required of all students prior to entering school)

Dtap: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____

Tdap: 1) _____

POLIO: 1) _____ 2) _____ 3) _____ 4) _____

MMR: 1) _____ 2) _____

Hepatitis B: 1) _____ 2) _____ 3) _____

Hepatitis A: 1) _____ 2) _____

Hemophilus B: 1) _____ 2) _____ 3) _____ 4) _____

Varivax: 1) _____ 2) _____ Disease: _____

Prenar: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____

Rotavirus 1) _____ 2) _____ 3) _____

Menactra: 1) _____

Other vaccines: _____

TUBERCULIN TEST (Mantoux Only) Date: _____ Results: _____

FINDINGS OF PHYSICAL EXAMINATION:

Height _____ Weight _____ Blood Pressure _____

Vision: R _____ L _____ Both _____ Hearing: R _____ L _____

Heart _____ Lungs _____ Abdomen _____

Skin _____ Speech _____ Hernias _____

Scoliosis _____

Please list any chronic health conditions or physical restrictions: _____

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Physician's Signature: _____ **Date:** _____