SBHC HEALTH MAINTENANCE RECORD

Name: _____ _____ _____
Last First Middle Initial

___M___F Date of Birth___/___/____ Student ID # _____ PCP _____ Ins: _____ PEMOSSA __Y / __N

Drug Allergies (write in red) _____**Reaction**_____
Other Allergies _____
Immunization Status _____
Hospitalizations/Surgeries _____
Significant Illnesses/Injury _____
Family Medical History _____

Problem List

Date	Chronic Problem	Date	Acute Problem	Date	Medication List	Prescriber

Physical Assessment

	Date/Notes	Date/Notes	Date/Notes	Date/Notes	Date/Notes	Date/Notes
Annual/EPSDT						
Dental Exam						
Vision Screen						
Auditory Screen						
Blood Pressure						
Bp %						
BMI %						
Other						

Student Health Questionnaire

(Please indicate if subject area as no concern, needs attention or risk factor)

Date of Review					
Home and School					
Health Behaviors					
Safety/Injuries					
Feelings/Well-Being					
Relationships/Sexual Activity					
Health Behaviors/Substance Use					
Development/Future Plans					
Provider initials					

Signature_____ Printed Name_____ Initials_____
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