Duchesne High School
Student Health Record

To be completed by parent or guardian:

Student Name: _____ Birthdate: _____

Parent / Guardian Name(s): _____ Parent Daytime Phone: _____

Allergies: _____ Medical Alerts: _____

Name of Physician or Clinic: _____ Phone: _____

Name of Dentist or Clinic: _____ Phone: _____

To be completed by physician or health care provider:

Height: _____ Weight: _____ BP: _____ Glasses: _____ Contacts: _____

Ear, Nose, Throat: _____ Hematology/Rheumat.: _____

Heart: _____ Neuro: _____

Lungs: _____ G.U.: _____

Abdomen: _____ Orthopedic/Spine: _____

Significant past illness: _____

Allowed to participate in strenuous activity such as in PE class: _____

Notes: _____

Immunization Record

Please upload Student Health Record and Immunization history to Blackbaud.

Important!

Records are required prior to the first day of school.

Physician Signature: _____ Date: _____