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 submit all pages of immunization records from your doctor.

Important!

Students cannot attend school if these records are not on file
in the main office the first day of school!

Fax: 636-946-6267
Mail: Duchesne High School
2550 Elm Street
St. Charles MO 63301

Physician Signature: ______________________________ Date: ____________