

TCA SCHOOL HEALTH REPORT

Section I – To be completed by parent/ guardian

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

HOME PHONE: _____

PHYSIAN: _____

PHONE: _____

ADDRESS: _____

DENTIST: _____

PHONE: _____

ADDRESS: _____

Is your child having any of the problems listed below?	Yes	No
1. Allergies or reactions: (For example, food, medication, or other		
2. Hay fever, asthma, or wheezing		
3. Eczema or frequent skin rashes		
4. Convulsion/ Seizures		
5. Heart trouble		
6. Diabetes		
7. Frequent colds, sore throat, earaches (4 or more per year)		
8. Trouble with passing urine or bowl movements		
9. Shortness of breath		
10. Speech problem		

Please explain any problem areas identified above:

Does your child take any medication regularly?

Yes

No

If yes, what medication? _____

Reason for medication? _____

Parent / Guardian Signature _____

