TCA SCHOOL HEALTH REPORT

Section I – To be completed by parent/ guardian

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ HOME PHONE: _____

_____

PHYSICIAN: _____ 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 _____

SECTION II – To be filled out by Physician

IMMUNIZATION RECORD

TYPE	DATE	DATE	DATE	DATE	DATE	DATE
DPT						
TD						
POLIO						
MMR						
HIB						
Hepatitis B						
Varicella						
Other						
Other						

Please list and describe any allergies to medications, food, or environment

_____

_____

_____ _____

Has child been prescribed Epipen Select Option

Inhaler Select Option

Vision Tested? ☐ Visual Acuity YES ☐ NO ☐ ☐ Ocular Muscles ☐ Other Date _____	Normal	Under care	Referred	Urinalysis Done? ☐ Sugar YES ☐ NO ☐ ☐ Albumin ☐ Microscopic Date _____	Normal	Under care	Referred
Hearing Test? YES ☐ NO ☐ ☐ Audiometer ☐ Other Date_____							
Hemoglobin/ Hemotocrit Tested? YES ☐ NO ☐							

PHYSICAL ASSESSMENT

PLEASE CHECK ONE:

☐ Entirely within normal limits

☐ Abnormalities as follows:

Is there any reason why the student cannot carry out full program of school work? Yes ☐ No ☐

If yes, what is the reason?

Doctor's Signature_____ Date_____

SECTION III To be filled out by Dentist
DENTIST'S REPORT

The following statements are applicable: (Please check)

☐ All necessary services have been performed

☐ No restorative services are required at this time

☐ Further treatment is indicated

☐ Further appointments have been arranged

Dentist's Signature _____