STUDENT MEDICAL HISTORY (TCA)

_____ _____ _____

Student Name Date of Birth Today's Date

Doctor's Name:_____Doctor's Phone Number:_____

Date of last physical exam:_____

Does your child have now or previously had any of the following? If YES, explain briefly on the line provided.

	YES	NO	
Allergies to medication			List:_____
Other allergies			List:_____Epi-pen? Yes No
Frequent headaches			_____
Convulsions/seizures			_____Date of last seizure:_____
Hearing impairment			_____
Visual impairment			_____Date of last eye exam:_____
Frequent ear infections			_____
Asthma			Inhaler? Yes No Triggers:_____
Hay fever			_____
Chronic bronchitis			_____
Sinus problems			_____
Heart abnormality			_____
Frequent stomach aches			_____
Frequent digestive issues			_____
Kidney disease			_____
Blood disease			_____
Frequent nosebleeds			_____
Diabetes			Insulin pump? Yes No _____
Hypoglycemia			_____
Thyroid disease			_____
Arthritis			_____
Orthopedic injuries			_____
Skin problems			_____
ADD/ADHD (circle one)			Age when diagnosed_____Medications? • Yes • No
Emotional problems			Please list:_____
Other			Please list:_____

Any other health problems or physical challenges which make participation difficult in classroom or physical activity?_____

List any medications being taken:_____

Does your student have any special needs or problems that should be known to better care for and meet his/her needs?_____

_____

Does your student use any assistive devices (e.g. glasses, hearing aid, braces, etc.)? • Yes • No
If yes, please list: _____

Parent Name:_____ Parent Signature: _____