

## 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: \_\_\_\_\_

Do you give permission for your student to use hand sanitizer? • Yes • No