Trafton Academy Student Profile Card 2019-2020

TO BE COMPLETED BY THE PARENT

_____

Student's Last Name First Name FALL Grade Level

Address:_____ City_____ Zip_____

Home Phone_____ Birthdate:_____ Age:_____ Male/Female

Mother's Name: _____ Cell #_____

Mother's Work #_____

Mother's E-mail:_____

Father's Name: _____ Cell #_____

Father's Work #_____

Father's E-mail: _____

Child lives with: Mother____ Father____ Both____

Person to call if the parents are not available:

Name: _____ Phone #_____

Hospital of choice: _____ Phone #_____

Insurer: _____ Policy # _____

Check the medications that may be dispensed to your child by the school.

□Tylenol □Advil □Tums □Zyrtec □Claritin □Benadryl □Midol

I have read and agree the information on this form is correct. I give permission for the information on this health form to be shared on a need-to-know basis in order to provide appropriate medical care for my child. In the event of an emergency, I authorize Trafton Academy permission to secure any transportation necessary for my child to be transported to a hospital. I authorize the hospital and any attending physicians to perform any and all diagnostic procedures and /or treatments required including blood transfusion(s). I will assume financial responsibility for the emergency medical transportation, emergency treatment, and any medical expenses incurred thereafter.

Parent's Signature: _____ Date: _____

Trafton Academy Student Health Form 2019-2020

TO BE COMPLETED BY A PHYSICIAN

HEALTH ASSESSMENT TO BE COMPLETED BY PHYSICIAN EACH YEAR

*********Please include a current copy of immunizations.**

HEIGHT:_____ **WEIGHT**:_____ lbs **BP**: _____

REQUIRED **VISION SCREEN**

With Correction: Yes___ No___

Right Eye 20/___ Left Eye 20/____

Pass ____ Fail ____ Referral ____

REQUIRED **HEARING SCREEN**

1000Hz 2000Hz 4000Hz

R_____I_____I_____Db

L_____I_____I_____ Db

Pass____ Fail____ Referral_____

REQUIRED **Scoliosis Screen Findings**

L	R		L	R	
□	□	High Shoulder	□	□	Rib hump
□	□	Shoulder blade stands out more than other	□	□	Obvious curve of spine in lower back
□	□	Obvious curve of the spine in area of rib cage	□	□	Hip higher than the other side
□		Round Back			

Recommendation: □ No Treatment □ Referral- Submit Professional Examination

REQUIRED **Acanthosis Nigricans**: □ Yes □ No

Is child on regular medication?

_____No ____Yes (If yes, Rx permission must be on file with the school.)

Please list prescription medications:

_____

Has he/she ever had a convulsion or seizure? □ Yes □ No

Notes:_____

Allergies? □ No □ Yes (If yes, list:_____

I certify that on this date I have examined the above student and recommend him/her as being **physically able to participate in supervised gym activities and/or join an athletic team.**

Physician's Signature: _____Date:_____

****The State of Texas requires all student files to be current on the first day of school. All forms and current immunizations are due by August 19, 2019. Your child will not be able to attend school until his/her file is complete.**