

Parents: Please complete both sides and sign this form.

Name of Student			
Male ___ Female ___	Age	Date of Birth	Grade
Home Address		City	Zip
Mother's Name		Home Phone	Work Phone
Email	Cell Phone		
Father's Name		Home Phone	Work Phone
Email	Cell Phone		
In case of emergency in which a parent cannot be reached, the following people are authorized for pick-up.			
A. Name / Relationship		Home Phone	Cell Phone
B. Name / Relationship		Home Phone	Cell Phone
Insurance Information (If you do not have insurance, indicate "NONE" in the blanks below.)			
Insured's Name			
Insured's SSN		Insurance Company	
Certificate or Policy Number		Group Number	
Employer		Contract Number	

Allergies

Food No Yes If yes, then list: _____

Medicines No Yes If yes, then list: _____

Bees/ Wasps/ Ants No Yes If yes, then list: _____

Indicate medication to be given if stung: _____

Other allergies: _____

Is child on regular medication? No Yes (If yes, Rx permission must be on file with school.)

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

Has s/he ever had a concussion, been knocked unconscious, or suffered a head injury?
 No Yes

I (we) _____, the parent(s), legal guardian(s), or managing conservator of _____, hereafter referred to as "child" request, agree, and give approval that, in case an injury to the child occurs at Trafton Academy or at a school-related activity and in the event I (we) or the physician indicated below cannot readily be reached, or if time is too critical to attempt to reach me (us), that the child be transported to a hospital at the discretion of school personnel or EMS for emergency care. I (we) further authorize the hospital and any attending physicians to perform any and all diagnostic procedures and/or treatments required including blood transfusions(s). In addition, I (we) authorize a Trafton Academy representative to secure any emergency medical transportation necessary. I (we) will assume financial responsibility for the emergency medical transportation, emergency treatment, and any medical expenses incurred thereafter.

Parent's signature

Physician's name, address, and telephone number

If needed, my child may have non-prescription medication upon request administered by school personnel. Circle and specify dosage: (e.g. 2 tablets)

Children's Tylenol/ acetaminophen Junior Tylenol Extra Strength Tylenol

Advil / ibuprofen Sudafed / pseudoephedrine

Benadryl / antihistamine Mylanta / Tums / antacid

Student's name _____

For new students, please complete immunizations in full; returning students update information

VACCINES	EXEMPT	DATE	DATE	DATE	DATE	DATE	DATE
DTP, DT, Td	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DPV, IPV	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Measles	_____	#1 ___/___/___	#2 ___/___/___	MMR #1	___/___/___	MMR #2	___/___/___
(1 & 2 required after 1 st birthday if born on or after 9/2/91)				(12-14 mos.)	(4 years)		
Mumps	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Rubella	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
TB test (current req'd)	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HIB CV	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hepatitis B	Required	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___			
Hepatitis A	_____	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___			
Varivax	___/___/___						
Chickenpox	___/___/___						

_____ R = religious exemption

_____ M = medical exemption

Parent's signature

Middle School Athletics
(Physical exam must be after April 1 of the current year.)

All Blank Spaces Must Be Completed

N=Normal X=Not Normal NE=Not Examined

___ Pulse ___ Skin ___ Ears

___ Eyes (clarity) ___ Nose ___ Throat

___ Lungs/Chest ___ Teeth

___ Abdominal Masses ___ Heart

___ Neurological ___ Spleen ___ Liver

___ Genitalia (male only) ___ Hernia ___ Spine

Joint Function:

___ Neck ___ Hands ___ Feet

___ Hips ___ Shoulders ___ Elbows

___ Knees ___ Wrists ___ Ankles

Optional: ___ HGB or Hematocrit

 ___ Urinalysis

Current School Year Physical

Ht: _____ Wt: _____ lbs. BP: ___/___/___

Physical exam -comments:

Present physical condition: _____

Limits on school activity, incl. P.E.? Y / N
If yes, then must have physician signature

Frequent illnesses? _____

Physicians Name

Has child been hospitalized? _____

Physician's signature

Cause: _____

Date of exam Phone

Surgeries: _____

Required Spinal (Scoliosis) Screening 6th and 8th
(completed at school - no cost)

Passed _____

Failed - Referred _____

Major Restorative Dentistry? Y / N

Dental appliances Y / N

Braces Y / N

Retainer Y / N

Is s/he missing any paired organ (eye, kidney, etc..)? Y / N

Required Vision Screening 5th and 7th
(Can be done privately or at school for minimal fee.)

Without glasses L _____ R _____

With glasses/contacts L _____ R _____

Referred _____

Required Hearing Screening 5th and 7th
(Can be done privately or at school for minimal fee.)

Sweep-Check L _____ R _____ Pass/Fail

Threshold L _____ R _____ Pass/Fail

Referred _____