

Trafton Academy Student Profile Card 2026-2027

TO BE COMPLETED BY THE PARENT

Student's Last Name _____ First Name _____ FALL Grade Level _____

Address: _____ City _____ Zip _____

Home Phone _____ Birthdate: _____ Age: _____ Male/Female
Child lives with: Mother ___ Father ___ Both ___

Mother's Name: _____ Father's Name: _____

Mother's E-mail: _____ Father's E-mail: _____

Mother's Cell #: _____ Father's Cell #: _____

Father's Address: _____

Emergency Contact:

Name: _____ Phone # _____

Name: _____ Phone # _____

Permission to pick up my child if parents are unavailable:

Name: _____ Phone # _____

Name: _____ Phone # _____

Hospital of Choice: _____ Phone # _____

Insurer: _____ Policy # _____ Phone # _____

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 that the information on this form is correct. I give my consent for the information on this health form to be shared on a need-to-know basis to provide appropriate medical care for my child. In the event of an emergency, I authorize Trafton Academy to secure any necessary transportation for my child to a hospital. I authorize the hospital and any attending physicians to perform 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 2026-2027

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 REQUIRED HEARING SCREEN

With Correction: Yes ___ No ___ 1000Hz 2000Hz 4000Hz

Right Eye 20/___ Left Eye 20/___ R ___ | ___ | ___ Db

Pass ___ Fail ___ Referral ___ L ___ | ___ | ___ Db

Pass ___ Fail ___ Referral ___

REQUIRED Scoliosis Screen Findings

- | | | | |
|---|----------|---|----------|
| L | R | L | R |
| <input type="checkbox"/> High Shoulder | | <input type="checkbox"/> Rib hump | |
| <input type="checkbox"/> Shoulder blade stands out more than other | | <input type="checkbox"/> Obvious curve of spine in lower back | |
| <input type="checkbox"/> Obvious curve of the spine in area of rib cage | | <input type="checkbox"/> Hip higher than the other side | |
| <input type="checkbox"/> Round Back | | | |

Recommendation: No Treatment Referral- **Submit Professional Examination**

REQUIRED Acanthosis Nigricans: Yes No

Is your 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 12, 2026. Your child will not be able to attend school until his/her file is complete.**