Thunderbird Christian Elementary

Training Children for Eternity

2024-2025 School Year

Student Medical Record

Only designated staff will have access to this completed form. This form will be stored in a locked file.

Name: _____ _____ _____ _____

Last First Middle Initial Date of Birth

Address: _____

Name of Father: _____ Name of Mother: _____

Medical History (Please check any previous or current illnesses and severe allergies)

☐ Cancer	☐ Heart Disease	☐ Whooping Cough	☐ Allergy to Latex
☐ Chicken Pox	☐ Measles	☐ Ear Infections (Chronic)	☐ Allergy to Penicillin
☐ Diabetes	☐ Rheumatic Fever	☐ Asthma	☐ Allergy to Nuts: _____
☐ Diphtheria	☐ Scarlet Fever	☐ Hay Fever	☐ Allergy to Insect Bites/Stings: _____
☐ Epilepsy	☐ Tuberculosis	☐ Other: _____	☐ Allergy to Other: _____

Does your student require access to: ☐ Inhaler ☐ EpiPen ☐ Insulin ☐ Other: _____

Please list any **non severe** allergies: _____

Briefly explain factors such as surgeries, accidents, injuries, congenital defects that might affect the child's school experience:

_____

Indicate any Developmental issues that may impact your child's educational experience (i.e: hearing, vision, speech, cognitive, etc.):

_____

Immunizations – *An official record of immunizations must accompany this record for all students entering school for the first time in the United States regardless of grade level. Records considered official are: State Immunization Record, Official Immunization Record from another state, School Immunization Record, Health Provider/County Health Department Record (must have signature, stamp or initials next to each date)*

Are you providing a complete record of Immunizations or a Personal Beliefs Exemption Form?

☐ Immunization Record ☐ Personal Beliefs Exemption Form

Hearing and Vision – *TCE periodically partners with Community Wellness & Safety of Arizona to offer screenings.*

Year of last hearing and vision screening: _____ Was a referral made? ☐ Yes ☐ No

Does your student require glasses to read or require the use of glasses in the classroom? ☐ Yes ☐ No

Does your student require a hearing device in the classroom? ☐ Yes ☐ No

Insurance Information – *In case of emergency and your student is taken to a medical provider we will provide them with this information.*

Insurance Provider: _____ Policy Number: _____ Group Number: _____

Primary Insured Individual: _____ Birthdate: _____

PHYSICIAN'S EXAMINATION*

(The rest of this form is to be filled out by a medical practitioner)

Name of Patient: _____ Date of Birth: _____Height: _____Weight: _____ Blood Pressure: _____

	Normal	Abnormal	Not Examined	Explain abnormalities:
Skin				
Eyes, Vision, Glasses				
Ears, Hearing				
Nose and Throat				
Mouth, Teeth, Speech				
Glands				
Chest, Lungs				
Cardiovascular, Heart				
Abdomen - enlargement				
Abdomen - tenderness				
Abdomen – hernia				
Spine, Back				
Scoliosis (For Grade 6)				
Posture				
Extremities				
Genitourinary				
Nervous System, Reflexes				

Nutritional Status and general appearance of the child: _____

Recommendations for additional medical or dental care: _____

Can this student participate unrestricted in normal physical education program which includes such activities as running, jumping, swimming, and tumbling. ☐ Yes ☐ No

If student must be restricted from participating in activities such as are listed above, please list accommodations that should be made: _____

Date of Examination: _____ Physician's Signature: _____

Address: _____

** To be completed by a physician and kept on file at the school for all children, a) entering school for the first time, b) at grade six (this should include the scoliosis examination), c) at other grades, when required by the Arizona Conference Board of Education.*