Trinity Charter School - New Student Health Information

Name_____ **Sex**____ **Grade**_____ **Birthdate**_____ **Teacher**_____

In order to provide an optimum environment, it is important that we have an understanding of your child's health status. Contact the school nurse is you wish to discuss any health problems in more detail.

Condition	**Yes**	**No**	**Please explain "Yes" answers**
Asthma			
Blood Transfusions			
Broken Bones			
Diabetes			
Head Injury			
Heart Condition			
Rheumatic Fever			
Fainting Spells			
Seizures			
Surgery			
Vision or Hearing Problems			
Other:			
Allergies:	***If at risk for ***ANAPHYLAXIS***, Allergy Emergency Action Plan is **REQUIRED**.		
Medication			
Food*			
Environmental			

Is he/she on medication?

Medication (Name & Strength)	**Dose/Frequency**	**Days Taken**	**Home**	**School**

*Is there any reason he/she can't participate in a full program, including physical education activities?
☐**Yes** ☐**No If yes, please explain** _____

*Have there been any stressful events in your child's life that could have an impact on his emotional well being? Example: death or serious illness in immediate family, major economic changes, abusive behavior, recent divorce or remarriage?
☐**Yes** ☐**No If yes, please explain** _____

*Has your child had chicken pox? ☐**Yes** ☐**No If yes, when? (month/year)** _____

*Has your child had any recent immunizations? ☐**Yes** ☐**No If yes, please attach physician documentation**.

Please give name, address and phone number of the doctor who last examined your child.

Name: _____ Address: _____Phone: _____

_____ _____

Date Signature of Parent/Guardian