Tyler Street Christian Academy
915 West Ninth Street • Dallas, Texas 75208
Phone 214.941.9717 • FAX 214.941.0324

| Name of Child: | | | | Date of Birth: | |
|---|---|---|---|---|---|
| IMMUNIZATIONS | Date / dose 1 | Date / dose 2 | Date / dose 3 | Date / booster | Date / booster |
| DTaP/DPT/DT/Tdap/Td | | | | | |
| POLIO IPV or OPV | | | | | |
| Hib | | | | | |
| Hepatitis B | | | | | |
| MEASLES Rubeola/Serampion | | | | | |
| MUMPS | | | | | |
| RUBELLA | | | | | |
| Hepatitis A | | | | | |
| Pneumococcal (PCV7) | | | | | |
| Meningococcal (MCV4) | | | | | |
| TB Test | ☐ Positive | ☐ Negative | Date: | | |
| Varicella | | | | | |

My child had varicella disease (chickenpox) on or about (date) _______________ and does not need varicella vaccine.

Parent's signature _______________ Date _______________

Signature – Physician or Health Personnel _______________ Date

Signature – Staff Making Handwritten Copy of Record _______________ Date

## REQUIRED PHYSICAL EXAMINATION

Skin/scalp _______________ Abdomen _______________ Hearing: Right_______________Left _______________

E.E.N.T_______________Limbs _______________ Vision: Right_______________Left_______________

Height _______________ Weight _______________

Chest _______________ Reflexes _______________

Mouth _______________Teeth _______________ Bones & Joints _______________

Heart & Circulation _______________ Other _______________

Does the school program need to be adjusted for this child? _______________ In what way? _______________

Is child's health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does child have any physical, mental, emotional disorders? _________ List: _______________

Has this child had any serious accidents or surgeries? _________ List: _______________

Does this child have any known allergies (food and/or drug)? _________ List: _______________

Does this child take any regular medications? _________ List: _______________ Purpose: _______________

Does this child have any known communicable disease(s)? _________ List: _______________

☐ Doctor's Statement: I have examined the above named child within the past year and find that he / she is physically able to take part in the day care/ school program.

Physician's signature _______________ Date _______________ Phone _______________

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# STUDENT HEALTH INFORMATION

Our desire is that your child profit in the greatest possible way from his/her school experience here at Tyler Street Christian Academy. To assist in accomplishing this, it is necessary to have a continuous health history on each student. **Please complete this form and return it to the school office or nurse.** Feel free to consult with school personnel on health problems at any time.

Student's Name ______________________________ MALE / FEMALE Date of Birth ____/____/____
First Middle Last

Address ______________________________ Phone ______________
Street City Zip Code

Father's Name ______________________________ Work Phone ______________
First Last

Mother's Name ______________________________ Work Phone ______________
First Last

If your child has had any of the following diseases, please state age at which he/she had them:

_____ Measles _____ Rheumatic Fever _____ Diabetes _____ Convulsions/Seizures
_____ Mumps _____ Pneumonia _____ Poliomyelitis _____ Human Immunodeficiency virus (HIV)
_____ Whooping Cough _____ Serious Accident _____ Kidney/Bladder _____ Hepatitis B virus
_____ Diphtheria _____ Asthma _____ Heart Disease
_____ Scarlet Fever _____ Hay Fever _____ Discharging Ears

Does your child have a physical, emotional, or congenital disability due to disease or accident? _________ Describe:_______________

Has your child ever had a skin test for tuberculosis? _________ Date ____/____/____ Results _________
Has he/she ever been closely associated with anyone known to have TB? _________ Date ____/____/____
Has he/she ever had a chest X-ray? _________ Date ____/____/____
Has your child ever been hospitalized? _________ List when and why (use separate sheet if needed): ______________

Please check any of the following that have been noted recently:

_____ Poor Vision _____ Allergy _____ Growing Pains _____ Any Crippling Condition
_____ Dizziness _____ Persistent Cough _____ Shortness of Breath _____ Four or More Colds Yearly
_____ Frequent Sties _____ Hard of Hearing _____ Speech Difficulty _____ Frequent Sore Throat
_____ Dental Defects _____ Tires Easily _____ Frequent Urination _____ Frequent Nose Bleeds
_____ Abdominal Pain _____ Hernia (Rupture) _____ Fainting Spells or Blackouts _____ Frequent Pain in Legs or Joints

Name of Child's Physician ______________________________ Date of last visit ____/____/____

Name of Child's Dentist ______________________________ Date of last visit ____/____/____

Signature of PARENT/GUARDIAN ______________________________ Date ____/____/____

**Please have your child's physician fill out the reverse side of this form and attach an official immunization record.**