Tabernacle Christian Academy

155 Academy Street • Poughkeepsie, NY 12601
Phone (845) 454-2792 • Fax: (845) 483-0926
A Ministry of Tabernacle Baptist Church

HEALTH EXAMINATION RECORD

Student's full name: ________________________________ ______ **M** ___ **F** ___ **Grade:** _________
(First) (Middle) (Last)

Home Address: ____
(No.) (Street) (City/Town) (State) (Zip Code)

Home Phone: ____________ **Father's Work Phone:** ____________ **Mother's Work Phone:** ____________
Cell # ____________ **Cell #** ____________

Date of Birth: ____________________

In case an EMERGENCY arises, list two persons who can be contacted if student's parents cannot be reached:

Name: ___________________________ **Address:** _________________________ **Phone:** ____________

Name: ___________________________ **Address:** _________________________ **Phone:** ____________

PHYSICIAN'S NAME: _______________ **Address:** _________________________ **Phone:** ___________

DENTIST'S NAME: _________________ **Address:** _________________________ **Phone:** ____________

Date of last Physician visit: ______________________ **Date of last Dentist visit:** ___________________

MEDICAL HISTORY (To be completed by parent or guardian)

DIRECTIONS: IN THE BLANKS, PLEASE PUT THE DATE WHEN THESE DISEASES OR HEALTH PROBLEMS WERE ENCOUNTERED.

Sickle cell anemia	Measles	Rheumatic fever	Mumps
Heart disease	Diabetes	Asthma/Allergies	Ear Condition
Chicken Pox	Epilepsy	Scarlet Fever	Diphtheria
German Measles	Pneumonia	TB	Frequent cold/ sore throat
Operation *	Serious Injuries*		

* **Give details of operations and/or serious injuries:** ____

____

Legal Requirements for Immunizations are waived because of:

a. Parent's Religious Beliefs _______________ **b. Physician Certificate** ________________

MEDICAL EXAMINATION AND RECORD OF IMMUNIZATIONS

NOTE: THIS IS TO BE COMPLETED BY A PHYSICIAN.

IMMUNIZATION OR TEST	DATE	DATE	DATE	DATE	DATE
POLIO - oral					
MMR (measles/ mumps/rubella)					
Hbcv (HIB)					
Hepatitis B					
DPT					
Other: ________					
Other: ________					
Tuberculin Test					
Vision Examination					
Sickle Cell Anemia					

HEIGHT	EYES
WEIGHT	NOSE
NUTRITION	GLANDS
TEETH	HEART
GUMS	LUNGS
TONSILS	ORTHOPEDIC (Defect)
EARS	(Posture)
	(Feet)

Recommendation of physician for follow-up and/or modification of school program:

1. Physical Education is (a) unrestricted _____ (b) restricted _______ for ______________ (HOW LONG)
2. Daily medication at home: ____

   Daily medication at school: ____
3. COMMENTS: ____

SIGNATURE OF PHYSICIAN: ______________________________ DATE: ____________