



One Sunset Avenue, Verona NJ 07044  
Phone: 973-509-3050 Fax: 973-509-3060 [www.tcischool.org](http://www.tcischool.org)

### **STUDENT MEDICAL FORM**

Please complete BOTH sides of this form and return immediately. Thank you. *Please print.*

#### **General Information**

Child's Name:		DOB:
Address:		
City:	NJ	Zip Code:
Parent/Guardian 1:	Parent/Guardian 2:	
Home Phone:( )	Home Email	

#### **Emergency Contact Information (in case of emergency, illness, accident)**

<b>Parent/Guardian 1:</b>	
Cell Phone:( )	Business Phone:( )
Business Name/ Address:	
Business Email	

<b>Parent/Guardian 2:</b>	
Cell Phone:( )	Business Phone:( )
Business Name/ Address:	
Business Email	

#### **Relatives/Friends for Emergency Use / Transportation**

<b>(1): Name:</b>		Relationship:
Cell Phone: ( )	Home Phone: ( )	Other: ( )
Address:		
<b>(2): Name:</b>		Relationship:
Cell Phone: ( )	Home Phone: ( )	Other: ( )
Address:		

#### **Medical Contact Information**

<b>Name of Physician/Health Clinic:</b>	Phone: ( )
Address:	
<b>Name of Dentist/Dental Clinic:</b>	Phone: ( )
Address:	
<b>Name of Prescribing Physician:</b>	Phone: ( )
Address:	

**TURN OVER – DOUBLE-SIDED DOCUMENT**



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**Family Medical History(Physical and/or Emotional Conditions)**

Mother:
Father:
Siblings:
Others:

**Student Medical Information**

<input type="checkbox"/>	<input type="checkbox"/>	Glasses/Contacts	Date of last eye exam:		
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aids Used	Date of last hearing check:		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice(yellow skin/eyes)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	IHP (Individual Health Care Plan)
<input type="checkbox"/>	<input type="checkbox"/>	Medication Allergies:			
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies:			
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal /Other Allergies:			

<b>Please list any other disease or problem NOT listed above including current medical conditions:</b>

<b>Please list all prescribed and over the counter medications your child is currently taking:</b>		
Medication:	Dose:	Time Given:
Medication:	Dose:	Time Given:
Medication:	Dose:	Time Given:
Medication:	Dose:	Time Given:
Medication:	Dose:	Time Given:
Medication:	Dose:	Time Given:

<b>Prior Hospitalizations:</b>			
Date:	Location:	Reason:	Treatment
Date:	Location:	Reason:	Treatment

Parent /Guardian Name(print)

Signature

Date

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