Torah Academy of San Antonio Medical Form

To be filled out by your child's health care provider (doctor (MD), nurse practitioner (NP), or physician's assistant (PA).

Student's name ______________________________________ Male ___ Female ____ Date of birth __/___/___

Current Health Issues

Yes	No	Condition	Please specify
		Allergies: to medications	
		Allergies: to foods	
		Allergies: other	
		History of anaphylaxis to _____________________	Epi-pen Yes_____ No ___
		Asthma	If yes please attach asthma action plan
		Diabetes	Type I ____ Type II ____
		Seizure disorder	
		Other: Please specify	

Current prescription medications taken: ____

This student has the following medical issues which may impact his or her educational experience:

Yes	No			YES	NO	
		Vision				Gross motor deficit
		Hearing				Social or emotional
		Speech/Language				Behavioral
		Fine motor deficit				Other

Comments/recommendations ____

Medical clearance:

Yes	No	
		This student may participate fully in the school program, including physical education, recess play, and competitive sports. If no, please list restrictions. ____

_____________________________________ __/__/__ _____________________________________

Signature of Examiner Date Printed name of examiner

Circle: MD NP PA

Group practice name ______________________ Telephone number __________________