



## 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 \_\_\_\_\_