One Sunset Avenue, Verona NJ 07044
Phone: 973-509-3050 Fax: 973-509-3060 www.tcischool.org

STUDENT MEDICAL FORM

Please complete BOTH sides of this form ad 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)

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

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

Relatives/Friends for Emergency Use / Transportation

(1): Name:		Relationship:
Cell Phone: ( )	Home Phone: ( )	Other: ( )
Address:		
(2): Name:		Relationship:
Cell Phone: ( )	Home Phone: ( )	Other: ( )
Address:		

Medical Contact Information

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

TURN OVER – DOUBLE-SIDED DOCUMENT

One Sunset Avenue, Verona NJ 07044
Phone: 973-509-3050 Fax: 973-509-3060 www.tcischool.org

Family Medical History(Physical and/or Emotional Conditions)

Mother:
Father:
Siblings:
Others:

Student Medical Information

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

Please list any other disease or problem NOT listed above including current medical conditions:

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

Prior Hospitalizations:			
Date:	Location:	Reason:	Treatment
Date:	Location:	Reason:	Treatment

Parent /Guardian Name(print)

Signature *Date*

TURN OVER – DOUBLE-SIDED DOCUMENT

Rev. 7/11 (CB)