



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: _____