



TFS Physical Form

This form is required for all new students, kindergarteners, & 7th graders. Print this form, complete the top and sign it. Your child's physician must complete the rest of the form. NOTE: if your doctor's office has a form, it is fine to use in lieu of this form as long as the form includes a current immunization record.

Due to TFS by Aug. 31st or within 30 days of start date at TFS.

Student Name _____ D.O.B. _____ Sex _____

Address _____ City/Zip _____

Primary Phone _____ Grade entering _____

All children entering TFS for the first time must have a current physical on file within 30 days of their first day of school.

Parent/Guardian Signature

Date

Immunization Record

DPT _____

Polio _____

DT/TD _____

HIB _____

MMR _____

Hepatitis B _____

Varicella _____

Meningococcal (MCV) _____

TB Test Type _____ Date _____ Results _____

Please List Any Allergies: _____

Height _____ Weight _____ BP _____ HCT _____ Chol _____ Urine _____

Vision Screening _____ Test Used _____ Results _____ R _____ L _____

Hearing Test--Within Normal Range ☐ YES ☐ NO Referral Date _____

Developmental Evaluation – Test Used _____

Within Normal Limits _____ Needs Follow-up _____





Student Name _____

Physical Examination (Please elaborate for abnormal results.)

Skin/Nodes _____ Chest/Lungs _____ Muscular/Skeletal _____
Head/Neck _____ Heart/Circulation _____ Neurological _____
E.E.N.T. _____ Genital/Urinary _____

Please check any of the following illness or behavioral difficulties the child has or has had:

- | | | |
|---|--|---|
| ☐ Asthma | ☐ Bleeding | ☐ Cystic Fibrosis |
| ☐ Bowel Problems | ☐ Seizures | ☐ Speech Problems |
| ☐ Heart Problems | ☐ Dental Problems | ☐ Diabetes |
| ☐ Ear Infections | ☐ Meningitis | ☐ Cancer/Leukemia |
| ☐ Hearing Problems | ☐ Skin Problems | ☐ Digestive/Stomach Problems |
| ☐ Bone/Muscle Problems | ☐ ADD/ADHD | |

Does this child take medication on a routine basis? If yes, list medication and possible side effects.

Does any medication need to be given at school? ☐ YES ☐ NO

If yes, please complete AUTHORIZATION TO GIVE MEDICATION FORM (below) indicating medication, time to be given, and dose.

List any medical, dental, developmental conditions, or disabilities which this child has and the extent to which these conditions might affect performance in school.

Has this child ever been hospitalized? If yes, please indicate when and what for.

List any other health considerations needed for this child while in school.

Physician Name (please print) _____

Physician Signature _____ Date _____

Address _____

Phone _____





**Authorization for Giving Medication
TFS, TFS Functions, & TFS Field Trips**

I request and authorize school personnel to give my child, _____

the following medication prescribed by _____
Doctor or authorizing adult / phone number

and to administer according to the written instructions on the medication container and/or this
written authorization.

<i>Name of Medication</i>	<i>Amount to be Given</i>	<i>Times to be Given</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other instructions concerning medication or administration of medication:

Side effects to be aware of:

Date

Signature of Parent/Guardian

