

# Student Health Record: Trinity School at River Ridge

**Instructions:** Parent/Guardian—please complete Sections A, B,  
Physicians—please complete Section D.

## Section A

Last name	First name	Middle name	Gender	Birth date

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Heads of Household \_\_\_\_\_ Work Phone \_\_\_\_\_

## Section B—Significant Past Illness History

Allergy (list)	Year	Seizures	Year
Asthma		Serious Injuries (list)	
Chicken Pox		Other Health Problems (list)	
Diabetes			
Hospitalization/Surgery (list reason)			

## Section C

Grade	Date	Height	Weight

Vision Screening												
Acuity		Muscle Balance		Color Vision		Corrective Lenses (ck)		Test Used & Comments		Hearing		
<b>R</b>	<b>L</b>	<b>P</b>	<b>F</b>	<b>P</b>	<b>F</b>			<input type="checkbox"/> TITMUS	<input type="checkbox"/> Snellen	<input type="checkbox"/> HOTV	<b>R</b>	<b>L</b>

### Comments:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Section D—Physician's Examination: Codes: O - essentially normal X - needs correction C - corrected

Eyes		Endocrine		Musculoskeletal		Gastrointestinal	
Ears		Heart / BP		Neuro		Nutrition	
Nose		Respiratory		Skin/Integument		Urinary	
Throat		Blood		Posture		Reproductive	

Any significant findings/recommendations: \_\_\_\_\_

**Cleared for all sports?** Yes No \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ Physician's Name (*print*) \_\_\_\_\_

Clinic Name and Address \_\_\_\_\_

**Date of Exam:** \_\_\_\_\_