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	
R	**L**	**P**	**F**	**P**	**F**			❑TITMUS ❑Snellen ❑HOTV	**R**	**L**

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: _____