Tualatin Valley Junior Academy
Student Medical Form

Student's Name_____Sex_____Date of Birth_____

Address_____City_____

State_____Zip_____Phone_____

Parent/Guardian Name_____Work Phone_____

Emergency Contact_____ Phone_____

Name of Physician_____Phone_____

Name of Dentist_____Phone_____

Hospital preference (if any) _____

Circle the following that your child has now or has had in the past:

Concussion	Yes	No	Year_____	Operations	Yes	No	Year_____
Skull Fracture	Yes	No	Year_____	Exposure to TB	Yes	No	Year_____
Neck Injury	Yes	No	Year_____	Rubella (3-day)	Yes	No	Year_____
Back Injury	Yes	No	Year_____	Rubella (7-day)	Yes	No	Year_____
Skin Disorder	Yes	No	Year_____	Mumps	Yes	No	Year_____
Eye Glasses	Yes	No	Year_____	Scarlet Fever	Yes	No	Year_____
Contact lenses	Yes	No	Year_____	Rheumatic Fever	Yes	No	Year_____
Eye Treatment	Yes	No	Year_____	Chicken Pox	Yes	No	Year_____
Hearing Disorder	Yes	No	Year_____	Urinary Problems	Yes	No	Year_____
Hernia	Yes	No	Year_____	Explain _____			
Diabetes	Yes	No	Year_____	Fainting	Yes	No	Year_____
Seizures	Yes	No	Year_____	Operations	Yes	No	Year_____

Comments on anything checked "yes" above, as well as any other medical information:

_____

_____

Allergies:

List **all** known allergies (Food, Insect Stings, Medicines, and Pollens)

_____

List any medications your child is taking _____

_____

Immunizations

Every Child between the ages of 3-14 years entering into Oregon public, Private or Parochial Schools for The first time must present evidence that his/her immunizations against DPT, Polio, MMR (Measles, Mumps and Rubella), Hepatitis B, and Varicella (Chicken Pox) are complete or up to date.

I hereby give permission for my child to receive emergency medical care. Information on this document may be made available to school and Health Department Officials.

Date_____ Parent/Guardian_____

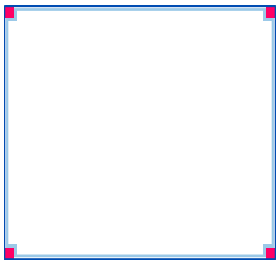
(Over)

EMERGENCY HEALTH CARE PLAN

Student's Name:_____

Allergy to: _____

Asthmatic ___ Yes* ____ No *(High risk for severe reaction)



Place child's picture here
School Use ONLY

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:**
o **MOUTH**	itching & swelling of lips, tongue, or mouth
o **THROAT***	itching and/or sense of tightness in the throat, hoarseness, and hacking cough
o **SKIN**	hives, itchy rash, and/or swelling around the face or extremities
o **GUT**	nausea, abdominal cramps, vomiting, and /or diarrhea
o **LUNG***	shortness of breath, repetitive coughing, and/or wheezing
o **HEART***	"thready" pulse, "passing out"

The severity of symptoms can change quickly. * All above symptoms can potentially progress to a life threatening situation!

ACTION

1. If ingestion is suspected, give_____
   and _____immediately!
2. CALL 911
3. CALL Mother _____Father_____
   or emergency contacts
4. CALL Dr _____@ _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____

PARENT SIGNATURE DATE

EMERGENCY CONTACTS:

1. _____
   RELATIONSHIP PHONE

2. _____
   RELATIONSHIP PHONE

3. _____
   RELATIONSHIP PHONE