Taejon Christian International School
Entrance Health Form

Since 1958

RECENT PHOTOGRAPH
3.5 cm x 4.5 cm

Student's Name (Last , First Name)	Date of Birth (yyyy/mm/dd)	Sex: Male ( ) Female ( )	Entering Grade: PreK K 1 2 3 4 5 6 7 8 9 10 11 12
Father's or Legal Guardian's Name:		Office Phone	Cell Phone
Mother's or Legal Guardian's Name:		Office Phone	Cell Phone
Home Address:			Home Phone
Emergency Contact Name:	Relationship:	Home Phone	Cell Phone
Health Insurance Information: Health Plan:	Policy Holder Name (가입자성명)	Identification #(관리번호):	Group #(증번호/사업장번호):

Permission is granted for:

( ) Tylenol
( ) Cough Syrup
( ) Ibuprofen
( ) Antacid
( ) Decongestant/Antihistamine
( ) Treatment of illness
( ) Throat Lozenges
( ) Emergency care

Parent's or Guardian's Signature: ____________________

Date : ____________________

In the event that I cannot be reached in an emergency, I give permission for my child to receive medical treatment, including transport to the most accessible hospital, as deemed necessary by school authorities.

Parent's Signature : ____________________

Date : ____________________

Health History

(To be completed and signed by parents/guardian)

Student's Name: ______________________________ Date of Birth: ______________________ Sex: Male ( ) Female ( )

To the best of your knowledge, has your child had any problems with following? Please check yes or no.

Medical Condition	Yes	No	Comments if "Yes"	Medical problem	Yes	No	Comments if "Yes"
ADD or ADHD				Hearing Loss			
Anemia				Heart disease			
Anxiety/Panic Attacks				Hepatitis			
Asthma				Pneumonia			
Behavioral problems				Rheumatic Fever			
Bleeding Disorder				Scoliosis			
Chronic ear infection				Seizures			
Developmental problems				Substance Abuse			
Depression				Tuberculosis			
Diabetes				Vision Problems			
Excessive Fatigue				Other			

*** Describe any serious illness, surgery, injuries, hospitalizations or allergies : ______________________________**

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*** Describe any other important health-related information about your child (i.e., feeding tube, hearing aid, Insulin device, etc.):______________**

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*** Has your child had any psychological testing & evaluation, or therapy? No ( ) Yes ( )**

If yes, please explain and attach the copy of the most current evaluation ______________________________

Immunization History

(Below this page to be completed by Healthcare provider or Physical doctor)

Student's Name: ______________________________ Date of Birth: ______________________ Sex: Male ( ) Female ( )

Type of Vaccine	1st Dose (M/D/Y)	2nd Dose (M/D/Y)	3rd Dose (M/D/Y)	4th Dose (M/D/Y)	5th Dose (M/D/Y) Kindergarten Entry
DPT					
Td Booster (at age 11-12 yrs.)					
Poliovirus					
MMR					
Hepatitis B					
Varicella			Date of Varicella Disease:		

Health care provider verifying above immunization history must sign. Signature/Date : ______________________________

***TB Mantoux test or chest X-ray required Every Two Years.**

TB skin Test or Chest X-ray : result ______________________________

Date completed______________________________

Doctor's Signature/Date ______________________________

Name of Clinic/Hospital ______________________________

TB Screening (office use only)					

Physical Examination

(to be completed by Physical Doctor)

Student's Name (last, first): ________________________ **Date of Birth(yyyy/mm/dd):** ____________________ **Sex (Male/Female)**

Height: __________________ **cm** **Weight:** _________________**lbs/kg** **Blood Pressure:** ________________**mmHg**

Hemoglobin:________________________________ **Urinalysis:** ____

System Examination	Normal	Abnormal	Comments about Findings	System Examination	Normal	Abnormal	Comments about Findings
General Appearance				Neck			
Skin				Chest			
Head				Heart			
Eyes				Lungs			
Ears				Abdomen			
Nose				Bones, Joints, Muscles			
Throat				Posture/Range of Motion			
Mouth/Teeth				Neurological			
Estimated Developmental Level	Cognitive Development						
	Speech/Language Development						
	Social/Emotional Development						

Recommendations: ____

Physician's/Nurse practitioner's Name (print): _______________________ **Signature:** ____________________ **Date:** _____________