Sts. Tarkmanchatz Armenian School
Student Medical Form

Child's name_____ Birth Date_____

Father's Name_____ Mother's Name_____

Address_____

_____

Height_____ Weight_____ Blood Group_____

Person to contact in an emergency_____ Phone_____

Child's regular doctor_____ Phone_____

Hospital regularly used_____ Phone_____

Is the child susceptible to any of the following?

- Asthma Yes/No
- Heart Problems Yes/No
- Frequent Fever Yes/No
- Nose Bleeds Yes/No
- Throat Infections Yes/No
- Rash Yes/No
- Convulsions Yes/No
- Hair Lice Yes/No
- Vision Problems Yes/No
- Skin diseases Yes/No
- Ear Infections Yes/No
- Chills Yes/No
- Headache Yes/No
- Colds Yes/No
- ADD Yes/No
- ADHD Yes/No
- Visual Problems Yes/No
- Aural Problems Yes/No
- Other_____

Does your child have any of the following?

- Food Allergy_____
- Drug Allergy_____
- Other Allergies_____
- Dietary Restrictions_____
- Physical Defects_____
- Health problems that require special attention_____

  _____
- Any other relevant information_____

  _____

Immunization Record:

Types of Diseases	Date		
DPT (Diphtheria/Pertussis/Tetanus	3 injections in 1 year …….	1st booster ……	2nd booster ……..
OPV	3 injections in 1 year ……..	1st booster ……	2nd booster ……..
Hepatitis B	1-	2-	
MMR (Measles/Mumps/Rubella)	1-		
Chickenpox			
Polio			
Meningitis			
Other			

Please attach to this form a copy of your child's Immunization card

Signature: _____ Date:_____