Shmuel Bass
TORAH ACADEMY
of San Antonio

Torah Academy of San Antonio Medical Form

**** To be filled out by your child's health care provider (doctor (MD), nurse practitioner (NP), or physician's assistant (PA). ****

Student's name _____ Male ___ Female ____ Date of birth ___/____/____

Current Health Issues

Yes	No	Condition	Please Specify
		Allergies: to medications	
		Allergies: to foods	
		Allergies: other	
		History of anaphylaxis to _____	Epi-pen Yes ___ No ___
		Asthma	If yes, please attach asthma action plan
		Diabetes	Type I ___ Type II ___
		Seizure disorder	
		Other: Please specify	

Current prescription medications taken: _____

This student has the following medical issues which may impact his or her educational experience:

Yes	No		Yes	No	
		Vision			Gross motor deficit
		Hearing			Social or emotional
		Speech/Language			Behavioral
		Fine motor deficit			Other

Comments/recommendations _____

Medical clearance

Yes	No	
		This student may participate fully in the school program, including physical education, recess play, and competitive sports. If not, please list restrictions:_____

_____ __/__/__ _____

Signature of Examiner Date Printed name of examiner

Circle: MD NP PA
Group practice name _____ Telephone number _____