Holy Trinity Lutheran School

553 Ashmoor Avenue • Bowling Green, KY 42101 • (270) 843-1001 Office • (270) 843-7466 Fax • www.htlsbg.com

P3-6th Grade
STUDENT MEDICAL FORM

P3-6th grade Student Medical Form. All students applying for admission to HTLS must complete and include this form when the application is submitted to the School Office.

In addition to this form: *(accepted K5 students only)*
All Kindergarten students accepted to HTLS will need to provide proof of a Kindergarten physical. The physical form must be completed by your doctor and turned in to the Admissions Office by the first day of school. This physical must be scheduled during the summer so that it will remain current for the student's entire Kindergarten academic year. Your doctor will provide the physical form. Your Kindergarten student will be unable to attend their first day of school without a physical form including updated immunizations on file.

Name of Student____Birth Date __________ Grade_______
Name of Parent or Guardian ____
Address ____________________________________City_______________State ____Zip__________

A. **Medical History**: (To be completed by the parent)

1. Is your child allergic to anything?_____Yes _____No If yes, what?________________________________
2. Is your child under a doctor's care?_____Yes _____No If yes, why?________________________________
3. Any previous hospitalizations or operations?_____Yes _____No If yes, what?____________________________
4. Is your child on any continuous medication? _____Yes _____No If yes, what?____________________________
5. Any history of diseases or recurrent illness? _____Yes _____ No If yes, what are they (diabetes, convulsions, heart trouble, etc.)?________
6. Does your child have any physical disabilities?______Yes _____No If yes, please describe:________________________
7. Does your child have any mental disabilities?_____Yes _____No If yes, please describe:________________________
8. Does your cild have any neurological or sensory disorders?_____Yes _____No If yes, please describe:__________________

B. **Immunization Record**: The health official must enter the date immunization was received in the space below **or** attach a copy of the immunization record.

Type of Vaccine:	#1	#2	#3	#4	#5
*DPT or DT (circle one)					
*Polio					
**Hib					
*MMR (combined doses)					
***Measles (two doses)					
Mumps (single dose)					
Rubella (single dose)					
***Hep. B (three doses)					
Varicella					
Other					

*Required by State Law ** Required by State Law if born on or after 10-1-91
***Required by State Law if born on or after 7-1-94

Health Official's Signature/Title________________________________**Date**_______**Phone**_____________