



HOLY TRINITY
 EPISCOPAL
 SCHOOL
 11810 LOCKWOOD
 HOUSTON, TEXAS 77044
 PH: 281-459-4323
 FAX: 281-852-4969

Health Record 2007-2008 School Year

Parents: Please complete the front and back of this form and sign

Student's Name _____

Birth date _____ Sex _____ Grade _____

Home Address _____

City _____ State _____ Zip Code _____

Mother's Name _____ Home Phone _____

Bus Phone _____ Cell Phone _____ Pager _____

Father's Name _____ Home Phone _____

Bus Phone _____ Cell Phone _____ Pager _____

IN CASE OF EMERGENCY IN WHICH A PARENT CANNOT BE REACHED, THE FOLLOWING PEOPLE ARE AUTHORIZED FOR PICK-UP:

1. Name/Relationship _____

Home Phone _____ Bus. Phone _____ Pager _____

2. Name/Relationship _____

Home Phone _____ Bus. Phone _____ Pager _____

3. Name/Relationship _____

Home Phone _____ Bus. Phone _____ Pager _____

Insurance Information (If you do not have family insurance, indicate "none" in the blanks below.)

Insured's Last Name _____ First _____ MI _____

Insured's Social Security Number _____ Carrier's Employer _____

Certificate or Policy Number _____ Group Number _____

Insurance Company _____ Contract Number _____

Insurance Company's Street Address _____

City _____ State _____ Zip _____

Allergies:

Food No Yes If yes, then list: _____

Medicine No Yes If yes, then list: _____

Bees/Wasps/Ants No Yes If yes, then list: _____

Indicate medications to be given if stung: _____

Other Allergies: _____

Is child on regular medication? No Yes

Indicate medication: _____

Has he/she ever had a convulsion or seizure? No Yes

Has he/she ever had a concussion, been knocked unconscious or suffered a head injury? No Yes

I (we), _____, the parent(s), legal guardian(s), or managing conservator of _____, hereafter referred to as "child," request, agree, and give approval that, in case an injury to the child occurs at Holy Trinity Episcopal School or at a school-related activity and in the event I (we) or the physician indicated below cannot readily be reached, or if time is too critical to attempt to reach me (us), that the child be transported to an appropriate hospital at the discretion of school personnel for emergency care. I (we) further authorize the hospital and any attending physicians to perform any and all diagnostic procedures and/or treatments required including blood transfusion(s). In addition, I (we) authorize a Holy Trinity Episcopal School representative to secure any emergency medical transportation necessary. I (we) will assume financial responsibility for the emergency medical transportation, emergency treatment, and any medical expenses incurred thereafter.

Physician's _____ Name Phone _____

Address _____ City _____ Zip _____

If needed my child may have non-prescription medication upon request administered by school personnel: (Circle)

Tylenol/acetaminophen Sudafed/pseudoephedrine Bacitracin/antibacterial ointment

Benadryl/antihistamine Mylanta/antacid Bactine Advil/ibuprofen

SIGNATURE OF PARENT/GUARDIAN _____ Date _____

Student's Name _____

TO BE COMPLETED BY PHYSICIAN

Immunizations (PLEASE COMPLETE IMMUNIZATIONS IN FULL)

VACCINES	EXEMPT	DATE	DATE	DATE	DATE	DATE	DATE
DPT, DT, Td	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
OPV, IPV	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
MEASLES	_____	#1 ___/___/___	#2 ___/___/___	MMR #1 ___/___/___	MMR #2 ___/___/___	MMR #1 ___/___/___	MMR #2 ___/___/___
		(1 & 2 required after 1st birthday if born on or after 9/2/91. Can be given with 2nd MMR)			(12-14 months)		(4 years)
MUMPS	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
RUBELLA	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
TB TEST (Current)	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HIB CV	_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HEPATITIS B SERIES (required)	_____	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___	VARIVAX ___/___/___		

_____ R=Religious Exemption _____ M=Medical Exemption

CURRENT SCHOOL YEAR PHYSICAL REQUIRED

Height _____ Weight _____ BP _____
 Present physical condition _____
 Frequent illnesses? _____
 Has child been hospitalized? _____
 Cause: _____
 Surgeries: _____
 Major Restorative Dentistry No Yes What kind: _____
 Dental Appliances No Yes What kind: _____
 Braces No Yes
 Retainer No Yes
 Is he/she missing any paired organ (eye, kidney, etc.)? No Yes
 Limits on school activity, including PE? No Yes
 I certify that I have examined this student and that he/she may compete in supervised athletic activities No Yes
 Physical examination • comment on significant findings: _____

*The parent must provide the School with the referred physician's report if the child has failed a required screening and is referred.

Physician's Name _____
 (Print or Type) Date of Exam _____

Physician's Signature _____

Physician's Phone _____

Required Vision Screening for Kindergarten, 1st, 3rd, 5th Grades and First Time Entrants
To be done by your doctor
 Without glasses L _____ R _____
 With glasses L _____ R _____
 Referred: _____
 Vision Screening: distance acuity for the right and left eyes must be Recorded, i.e., 20/20, etc. Approved charts are (1) Snellen Letter Chart, (2) Snellen "Tumbling" Chart (3) HOTV Matching-Symbol Test.

Required Hearing Screening for Kindergarten, 1st, 3rd and 7th
To be done by your doctor
 Sweep-Check L _____ R _____ Passed/Failed
 Threshold L _____ R _____ Passed/Failed
 Referred: _____
 Hearing Screening: the results of the pure-tone audiometric Sweep-Check Test must be recorded for both the right and left ears. A Sweep Check Test is to be conducted at an intensity of 25 dB (or less) at the following frequencies: 500, 1000, 2000, and 4000 Hertz. When the pure-tone Threshold Test is completed due to failure of the second Sweep-Check Test, the results should also be recorded.

SPINAL (SCOLIOSIS): Required for all 5th graders

Results: _____ Diagnosis: _____

*Referred: _____ Treatment: _____

*The referred physician's report is required if the child has failed a required screening.