



Student Medical Form

Must Be Completed Each School Year

2023-2024

Child's Name:	Date of Birth:
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List below **ANY** conditions, (dating from birth) that your child may currently have or have had in the past, (allergies, illness, injury, surgery) or medications prescribed for long-term use and any other information of which staff should be aware.

- If your child has severe allergies or needs medication during school please complete the TES Medical Action Plan
- If no allergies or medical conditions

Developmental

Is your child receiving any special services? Speech, Occupational Therapy, Physical Therapy, or Adjunct Services, etc?

Are you concerned about any of your child's developmental milestones at this time?

Hearing and Vision Screening

The State of Texas requires that all four and five year children have a hearing and vision screening before the start of school. Hearing and Vision screenings are also recommended for 3-year-old children.

Please check all that apply:

- My child's vision was tested at a physician's office and I will submit a copy of that test.
- My child's hearing was tested at a physician's office and I will submit a copy of that test.
- My child is two or three and does not require testing at this time.

Hearing and Vision Screening Results

- Vision screening results _____
- Hearing screening results _____
- Results Attached

Immunization

- All immunizations are current, please attach forms.
- If Immunizations are on a delayed vaccination schedule you must provide documentation (signed by a physician) to that effect and attach to this form. **This must be approved by the Director before the start of school.**
- If immunization would be medically injurious to your child, you must obtain a certificate from the State (signed by a physician) to that effect and attach it this form. **This must be approved by the Director before the start of school.**

***In order to protect all children in our care, TES does not accept waivers of Conscience.**

Physician's Office or Clinic's Statement:

- This child **has been examined** within the past 11 months and found that he/she is physically able to take part in the Trinity Episcopal School program.

Signature of Physician: _____ Date: _____

Printed name of Physician: _____

I certify that all statements made above are true.

Signature of Parent or Legal Guardian: _____ Date: _____

Printed name of Parent or Legal Guardian: _____