12535 Perthshire Road
Houston, TX 77024

TO BE COMPLETED BY THE PARENT					
Name:			Grade:		
Address:					
Birthdate:		M / F	Phone:		
Allergies?	Y N		(see extra form)		
EpiPen?	Y N	Inhaler?	Y N	Allergy Action Plan?	Y N
Special needs, hospitalizations or surgeries?			Y N (if yes, attach notes)		
Daily medications:					
Check over the counter medications your child may have while on campus					
☐ Tylenol	☐ Advil	☐ Benadryl	☐ Tums		
Medical/Religious exemptions?		☐ Y ☐ N (attach certificate with Y)			
Mother's Name:					
Father's Name:					
Parent contact information					
Mother's Work:		Mother's Cell:			
Father's Work:		Father's Cell:			
Mother's Email:					
Father's Email:					
Person(s) to call if parents are not available					
Name:		Phone:			
Name:		Phone:			
Health Information Release					
I have read and agree the information on this form, with any initialed changes is correct. I give permission for the information on this health form to be shared with school personnel on a need-to-know basis, to provide appropriate services for my child. I agree to notify the school of any changes in my child's health status.					
Emergency Treatment Release					
►Parent Signature:		Date:			
Child's Doctor:		Phone:			
Insurer:		Policy #:			

TO BE COMPLETED BY A PHYSICIAN					
Yearly physical is required					
Height:		Weight:		Blood Pressure:	
Pulse:		Scoliosis:	Pass / Observation / Referred		
Vision:	**R:** 20/ **L:** 20/	Vision Correction:	Glasses / Contacts		
Auditory:	**R:** Pass / Fail	**L:** Pass / Fail			
Acanthosis Nigricans:	Y N				
	Student cleared for participation in activities and athletics.				
	Student cleared after completing evaluation or rehabilitation for				
	Not cleared for				
Notes/Abnormalities:					
Exam	Within Normal Limits?				
Cardiovascular					
Abdomen	Y	N (explain)			
Neuro	Y	N (explain)			
Respiratory	Y	N (explain)			
GU	Y	N (explain)			
Musculoskeletal	Y	N (explain)			
HEENT	Y	N (explain)			
Notes:					
All students, new and returning, must provide updated Immunization Records with this form.					
►Physician Signature:		Date:			
I certify that on this date I have examined the above student and recommend as physically able to participate in supervised activities and/or join an athletic team.					

RETURN THIS COMPLETED FORM AND UPDATED IMMUNIZATION RECORDS BY AUGUST 1, 2023