



Al-Hadi School of Accelerative Learning

2313 S. Voss Rd.
Houston, Texas 77057
(713) 787-5000 ext. 2500
Fax (713) 513-5315

HEALTH / MEDICAL INFORMATION FORM

SCHOOL YEAR: _____ GRADE: _____

To be completed by Parent or Guardian. Please Print.

Child's Name _____ Sex: M / F DOB: _____
First Middle Last Month Day Year

Address _____
Street City Zip Code

Father's Name _____ Telephone _____
First Last Home Work

Mother's Name _____ Telephone _____
First Last Home Work

List any special problems that your child may have, such as **allergies**, existing illness, previous serious illness, injuries, psychological or emotional difficulties during the past 12 months, any **medication** taken daily (over-the-counter or prescription), and any other information which the staff should be aware of:

IMMUNIZATION RECORD

(See attached list of Texas requirements)

		1	2	3	4	5	6	
TO BE COMPLETED BY PHYSICIAN	DPT DPTaP DT							
	Polio OPV, IPV							
	HIB							
	MMR							
	Measles Only							
	Hepatitis B							
	Varicella							Or approx. date of varicella disease: _____
								Complete documentation form on reverse side.
	TB Skin Test <i>(Required for KG & Up)</i>							

(OVER)

DOCUMENTED HISTORY OF VARICELLA DISEASE

Please complete this section if your child has already had the Varicella disease (Chickenpox).

“This is to verify that _____ had Varicella disease (Chickenpox) on or about _____ and does not need Varicella vaccine.”
(name of child)
(date)

Parent/Guardian Signature: _____ Relationship to Student: _____

Date: _____

HEARING / VISION SCREENING

HEARING SCREENING 1ST

at 25dB	R	L
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		

PASS FAIL
 RESCREEN

Signature: _____

Date: _____

HEARING SCREENING 2ND

at 25dB	R	L
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		

PASS FAIL
 RESCREEN

Signature: _____

Date: _____

VISION SCREENING 1ST

DISTANCE ACUITY: R - 20/ _____ L - 20/ _____

PASS FAIL
 RESCREEN Date: _____

Signature: _____

Date: _____

VISION SCREENING 2ND

DISTANCE ACUITY: R - 20/ _____ L - 20/ _____

PASS FAIL
 RESCREEN Date: _____

Signature: _____

Date: _____

IMPORTANT:

DOCTOR'S STATEMENT

“I find that the above-named child is physically able to take part in all physical activities of Al-Hadi School.”

Exceptions: _____

Last Exam Date: _____

Physician's Signature: _____

Date: _____