

The Westwood School **INITIAL** Health Record - 14340 Proton Rd., Dallas, TX 75244 (972) 239-8598

****Must be completed before your student's application will be considered for admission.***

Please complete every line putting n/a where necessary. **Our licensing requires that no student be admitted to start school without the entire form completed and no refund will be given for days your student is unable to attend because this form is incomplete.** Updated immunization records must be submitted within two weeks of your student's birthday.

Student's Name _____ Birth date _____
First Middle Last Month Day Year

Mother's/Guardian's Name _____ Telephone # _____
First Last Home Work Cell

Father's/Guardian's Name _____ Telephone # _____
First Last Home Work Cell

Medical Insurance Co. Name _____ Policy #/Group # _____
 Address _____ Phone # _____

In case of an emergency in which the parents cannot be reached, please call:
 Name Relationship Telephone #'s
 1. _____
 2. _____

Health History

Does this Student:			have previous serious illness(es)?	Yes	No
have existing illness(es)?	Yes	No	If yes, please name:	_____	
have previous serious injuries?	Yes	No	have any hospitalizations in the last 12 months?	Yes	No
If yes, please describe:	_____		If yes, please describe:	_____	
have any non-seasonal allergies?	Yes	No	have any seizures?	Yes	No
If yes, please name:	_____		If yes, please give reason:	_____	
take daily medications?	Yes	No	Are there any parental concerns?	Yes	No
If yes, please name:	_____		If yes, please list:	_____	

Name of Child's Doctor _____ Telephone # _____
 Address _____

Releases-Please initial all authorized releases.

- _____ **Permission for water activities:** I hereby give consent for my child to participate in water activities including, splashing pools(), wading pools(), swimming pools(), and other bodies of water().
 - _____ **Permission for Field Trips and School Outings:** I hereby give permission for my child to go on school excursions to places of interest and recreation, on field trips, etc., with the understanding that supervision is provided by authorized personnel of the school, and that all possible precautions are taken to ensure the health and safety of the students.
 - _____ **Permission to Administer Tylenol:** I hereby give my consent for my child to be administered Tylenol according to the directions on the bottle.
 - _____ **Authorization for Emergency Medical Attention:** In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to the closest medical facility.
 - _____ **Permission to apply Sunscreen and/or Diaper Rash Cream:** I give permission to the staff of The Westwood School to apply Sunscreen/Diaper Rash Cream as needed to my child.
- The undersigned parent or guardian gives permission for all above releases.**

Printed Name _____ Date _____ **Parent Signature X** _____

Student's Name _____

Diagnosis of physical or mental impairment: _____

Limited activities (list activities in which child should not participate): _____

Medication prescribed on regular basis (Must be in original container if administered at facility): _____

Special Diet: _____

Suggested Referrals: _____

Doctor's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the school/day care program and is free of communicable disease.

Physician's Signature _____ Date _____

RELEVANT HEALTH INFORMATION (By Physician):

Present Age _____ yrs. _____ mos. Height _____ Weight _____
 Blood Pressure _____ / _____ mm HG Hematocrit or Hemoglobin _____
 Other Tests (if indicated) (1)Sickle Cell _____ (2)Lead _____ (3)Ova and
 Parasites _____ (4)Urinalysis _____ (5)HIV _____ (6)Other _____

IMMUNIZATION RECORD (by Physician):

Vaccine	Date Given	Validation
DPT ()	1. _____	_____
Td ()	2. _____	_____
DT ()	3. _____	_____
	4. _____	_____
	5. _____	_____
Polio	1. _____	_____
Oral ()	2. _____	_____
IPV ()	3. _____	_____
	4. _____	_____
	5. _____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hemophilus	_____	_____
Varicilla/varvax	_____	_____
Other	_____	_____

TB Test Date _____ Result _____

Physician's verification of measles/mumps/chicken pox illness - This is to verify that the child named above had:
 () measles illness on or about _____
 () mumps illness on or about _____
 () chicken pox on or about _____
 and does not need the vaccine(s).

SPECIAL SENSES SCREENING RECORD

Visual acuity and hearing sensitivity screening are required for 1st, 3rd, 5th, & 7th grades. Rescreening is only required if an abnormality was noted on the first screening. Speech screening is optional (not required).

Hearing Screening

1st			2nd		
at 25dB	R	L	at 25dB	R	L
500 Hz	_____	_____	500 Hz	_____	_____
1000 Hz	_____	_____	1000 Hz	_____	_____
2000 Hz	_____	_____	2000 Hz	_____	_____
4000 Hz	_____	_____	4000 Hz	_____	_____
Pass ()			Pass ()		
Fail-rescreen ()			Fail-refer ()		
Date	_____		Date	_____	

Signature _____

Vision Screening

1st		2nd	
Distance	Acuity:	Distance	Acuity:
R-20/_____	L-20/_____	R-20/_____	L-20/_____
Pass ()		Pass ()	
Fail () rescreen		Fail () refer	
Date	_____	Date	_____

Signature _____

Signature _____

Signature _____

