

East Texas Christian Academy  
**STUDENT MEDICAL RECORD**

*Please complete both sides*

Child's Name: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

**In case of illness or emergency, notify either of the following:**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
Name Name

Phone #: (H/W) \_\_\_\_\_ (C) \_\_\_\_\_ Phone #: (H/W) \_\_\_\_\_ (C) \_\_\_\_\_

Relation: Mother - Father - Grandparent - Friend Relation: Mother - Father - Grandparent - Friend

Neighbor - Other: \_\_\_\_\_ Neighbor - Other: \_\_\_\_\_

*In case of an accident or sudden illness to my child and in the event that I or the people named above cannot be reached by telephone, I hereby authorize a representative of East Texas Christian Academy to give consent for any necessary emergency medical care for my child.*

\_\_\_\_\_  
Parent/Guardian Signature

**Health Admission Statement**

*Evidence of your child's health must be presented when accepted for enrollment. One of the following must be met:*

1. \_\_\_\_ An Early Periodic Screening Diagnostic and Treatment (EPSDT) medical screening form, with no further diagnosis and treatment indicated, is attached.
2. \_\_\_\_ A form or written statement from a health service or clinic is attached.
3. \_\_\_\_ A licensed physician's statement is attached.
4. \_\_\_\_ An appointment has been scheduled for an examination on \_\_\_\_\_ with Dr. \_\_\_\_\_ at \_\_\_\_\_.
5. \_\_\_\_ My child has been examined by the physician below within the past twelve (12) months and is physically able to participate in any program at ETCA.

\_\_\_\_\_  
Physician/Health Personnel

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

**NOTE:** *The Health Admission Statement above must be signed by the parent or guardian and by the child's physician.*

(Over)

**IMMUNIZATIONS:** A current copy of your child's immunization record is required upon acceptance for enrollment. Please attach a copy to this form.

\_\_\_ Immunizations are complete and copies are attached.

\_\_\_ Immunization records are incomplete because:

1. \_\_\_ Immunizations are harmful to child's health or well being or to a member of child's family.
2. \_\_\_ Immunizations have begun and will be completed as soon as medically feasible.
3. \_\_\_ Illness of child. Immunizations will be completed as soon as medically feasible.
4. \_\_\_ Attached is an affidavit stating that immunizations conflict with the tenets & practices of \_\_\_\_\_, of which I am a member.

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Please indicate below any special problems, allergies of any kind (food, drugs, etc.) or special needs of your child.

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Existing illnesses: \_\_\_\_\_

Previous Illnesses/Injuries: \_\_\_\_\_

Hospitalization within past 12 months: \_\_\_\_\_

Medication prescribed for long-term continuous use: \_\_\_\_\_

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| If your child is on medication daily for any reason, please complete the following: |            |        |        |
|---|------------|--------|--------|
| Condition   | Medication | Dosage | Doctor |
|   |            |        |        |
|   |            |        |        |
|   |            |        |        |