Temple Christian Learning Center
a ministry of Temple Baptist Church

Medical History Form

2020-2021

2501 Northshore Blvd.
Flower Mound, TX 75028
Phone: 972-539-1298
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www.templebc.org

It is mandatory that students who show symptoms of a communicable disease be excluded from classes until re-admission is acceptable to the school administration. Your cooperation is greatly appreciated.

Student's Name: _____ Birthdate: _____ Sex: ☐ F ☐ M

Home #: _____ Father's Work #: _____ Mother's Work #: _____

Past Diseases
(If your child has had any of the following, please state the age when he/she had them.)

Measles	_____	Diphtheria	_____	Polio	_____
Mumps	_____	Scarlet Fever	_____	Convulsions	_____
Whooping Cough	_____	Rheumatic Fever	_____	Heart Disease	_____
Asthma	_____	Chicken Pox	_____	Discharging Ears	_____
Flu	_____	Diabetes	_____	HIV (Aids)	_____
Hay Fever	_____	Pneumonia	_____		

Recent Disabilities
(Please check all that are applicable.)

☐	Frequent Colds	☐	Fainting Spells	☐	Hearing Difficulty
☐	Frequent Sore Throat	☐	Abdominal Pains	☐	Tires Easily
☐	Poor Vision	☐	Frequent Urination	☐	Breath Shortness
☐	Frequent Leg Pain	☐	Growing Pains	☐	Hernia (rupture)
☐	Dizziness	☐	Persistent Cough	☐	Ringworm
☐	Frequent Sties	☐	Speech Difficulty	☐	Nose Bleeds
☐	Dental Defects	☐	Crippling Conditions		

Personal Record
(Please answer all of the following.)

☐ Yes	☐ No	Is He/She Shy	☐ Yes	☐ No	Overactive	☐ Yes	☐ No	Bites Fingernails
☐ Yes	☐ No	Sucks Thumb	☐ Yes	☐ No	Has Excessive Fears	☐ Yes	☐ No	Has Temper Tantrums
☐ Yes	☐ No	Like School	☐ Yes	☐ No	Plays Well With Others	☐ Yes	☐ No	Eats Breakfast
☐ Yes	☐ No	Immunizations to Date	☐ Yes	☐ No	Immunization Records Attached			
☐ Yes	☐ No	Free from Communicable Diseases			If no, explain ._____			

Does your child have a disability due to disease or accident? ☐ Yes ☐ No If yes, explain._____

Has your child had a skin test for tuberculosis? ☐ Yes ☐ No Date: _____

Has he/she been associated with a tubercular patient? ☐ Yes ☐ No

List any hospitalizations, operations or serious illnesses. _____

Does your child have allergies? ☐ Food ☐ Bee or Insect Stings ☐ Drugs ☐ Other *(If you marked Food or Stings, please complete the Allergy Action Plan Form)* If any marked, please explain: _____

_____

MEDICATION

Is the applicant on any medication? ☐ **Yes** ☐ **No** *(If yes, and medication must be administered by the Learning Center Director, please also read the Medication Policy and attach the Medication Disbursement Form.)*

What kind? _____ **How often?** _____

EMERGENCIES

Child's Physician: _____ Phone: _____

Physician's Address: _____

Insurance Company: _____ Policy #: _____

PERSON TO BE NOTIFIED (OTHER THAN PARENT(S)/GUARDIAN(S) IN AN EMERGENCY.

Name: _____ Phone: _____

AUTHORIZATION FOR MEDICAL TREATMENT:

I HEREBY AUTHORIZE MEDICAL PERSONNEL AND/OR HOSPITAL EMERGENCY STAFF TO ADMINISTER ANY EMERGENCY TREATMENT, PROCEDURE, OR MEDICINE NECESSARY WHEN TEMPLE CHRISTIAN LEARNING CENTER PERSONNEL ACCOMPANY (CHILD'S FULL NAME) _____ TO THE EMERGENCY ROOM. I ALSO AUTHORIZE TEMPLE CHRISTIAN LEARNING CENTER PERSONNEL TO SECURE THE USE OF AN AMBULANCE IF NECESSARY. I AGREE TO PAY THE HOSPITAL, DOCTORS, AND AMBULANCE SERVICE FOR ALL SERVICES RENDERED TO THE ABOVE PATIENT.

IF YOU DO NOT GIVE PERMISSION OR AUTHORIZATION TO GIVE CONSENT FOR MEDICAL TREATMENT, WHAT PROCEDURE SHOULD BE FOLLOWED?

_____

_____

_____

SIGNED: _____ DATE: _____
PARENT OR GUARDIAN

RELEASE OF LIABILITY:

I ABSOLVE TEMPLE CHRISTIAN LEARNING CENTER FROM ANY LIABILITY TO MY CHILD BECAUSE OF AN INJURY TO MY CHILD WHILE AT TEMPLE CHRISTIAN LEARNING CENTER, ANY LEARNING CENTER-SPONSORED ACTIVITY, SPORTS PRACTICE OR SPORTS GAME SPONSORED BY TEMPLE CHRISTIAN LEARNING CENTER.

SIGNED: _____ DATE: _____
FATHER'S SIGNATURE

SIGNED: _____ DATE: _____
MOTHER'S SIGNATURE

CERTIFICATION:

I DO HEREBY CERTIFY THAT ALL OF THE INFORMATION CONTAINED WITHIN THIS DOCUMENT IS CORRECT AS OF THE DATE SIGNED.

SIGNED: _____ DATE: _____
PARENT OR GUARDIAN

IMMUNIZATION RECORD

☐ I have provided Temple Christian Learning Center a copy of my child's most current immunization record.

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit from developed and issued by the Department of State Health Services. I understand that this affidavit is valid for two (2) years.

HEALTH CARE PROFESSIONAL'S STATEMENT (Requirement of Admission)

If your child does not attend pre-kindergarten or school away from Temple Christian Learning Center, one of the following must be presented when your child is admitted to Temple Christian Learning Center or within one (1) week of admission.

☐ Health Care Professional's Statement: I have examined the above named child within the past year and find that he/she is able to take part in the day care program.

_____ _____

Health Care Professional's Signature (M.D. or Nurse Practitioner) **Date**

☐ A signed and dated copy of a health care professional's statement is attached.

☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

VISION AND HEARING SCREENING (4 YEAR OLDS ONLY)

Vision	R 20/ _____	L 20/ _____	☐ Pass ☐ Fail

Signature _____ Date _____

Hearing	**1000 Hz**	**2000 Hz**	**4000 Hz**	☐ Pass ☐ Fail
R				
L				

Signature _____ Date _____

_____ _____

Parent of Legal Guardian's Signature Date