

**Colonial Hills United Methodist School**  
**2019-2020 MEDICAL FORM REQUIRED for ADMISSION**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Admission Requirement: Please check only one option:**

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is free from communicable diseases and is able to take part in school.

\_\_\_\_\_  
Health Care Professional's Signature

\_\_\_\_\_  
Date

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

3. ☐ A 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.

**The name and address of health care professional who saw my child is:**

\_\_\_\_\_

\_\_\_\_\_  
Signature – Parent or Legal Guardian

\_\_\_\_\_  
Date

**\*If your child will be 4 or older by September 1, 2019, you will need to provide a hearing and vision screening from your physician.**

<b>VISION</b>	R 20/ _____	L 20/ _____		<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Signature _____	Date _____			
<b>HEARING</b>	1000 Hz	2000 Hz	4000 Hz	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
R				
L				
Signature _____		Date _____		

**AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:**

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Emergency Medical Care Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

I give consent for the facility to secure any and all necessary emergency medical care for my child.

\_\_\_\_\_  
Signature - Parent or Legal Guardian

**Immunization Record:**

- ☐ I have provided the school with 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 form developed and issued by the Department of State Health Services. I understand the affidavit is valid for 2 years.

For additional information regarding Immunizations contact the Department of State Health Services at [www.dshs.state.tx.us/immunize/public.shtm](http://www.dshs.state.tx.us/immunize/public.shtm)

\_\_\_\_\_  
Signature – Parent or Legal Guardian

\_\_\_\_\_  
Date

1/07/2019 LL