

Harvest Christian School
7501 Crowley Road
Fort Worth, TX 76134
Phone: (817) 568-0021
FAX: (817) 568-1395

HEALTH AND SAFETY INFORMATION

CHILD'S NAME _____ **AGE** ____ **GRADE** _____

ADDRESS _____
Street City Zip

PARENT'S NAME _____ **TELEPHONE #** _____
Home Work

HEALTH HISTORY:

CHILDHOOD DISEASES _____

SEVERE ILLNESSES/ACCIDENTS/SURGERIES _____

DISABILITIES (Physical or Learning) _____

ALLERGIES _____ **TYPE OF REACTION** _____

REGULAR MEDICATIONS TAKEN _____

ARRIVAL AND DEPARTURE INSTRUCTIONS:

APPROXIMATE TIME YOUR CHILD WILL ARRIVE HERE: _____ A.M. _____ P.M.

NAME/PHONE NUMBERS OF PERSONS TO WHOM YOUR CHILD MAY BE RELEASED:

PERMISSIONS: (Please Initial)

_____ My child has permission to ride in the transportation provided for school sponsored activities.

_____ My child has permission to participate in water activities. Ability level: _____

EMERGENCY INSTRUCTIONS:

If I cannot be reached for emergency attention in the event of illness or accident, I hereby authorize HARVEST CHRISTIAN SCHOOL to take my child to:

Child's Doctor Address Telephone #

Hospital or Clinic Address Telephone #

HEALTH INFORMATION

STUDENT'S NAME _____ BIRTHDATE _____

VACCINES	DATE GIVEN	VALIDATION DOCTOR OR CLINIC
DTP — Td — DT —	1.	
	2.	
	3.	
	4.	
	5.	
Polio — Oral — IPV —	1.	
	2.	
	3.	
	4.	
	5.	
Measles		
Mumps		
Rubella		
Other		
HIB		
TB TEST		RESULT:

Visual acuity and hearing sensitivity are required for all children entering our school age four (4) and above. Re-screening is only required if an abnormality was noted on the first screening.

HEARING SCREENING:

1ST

at 25dB	R	L	
500Hz			_ Pass
1000Hz			_ Fail
2000Hz			RESCREEN
4000Hz			_____

Date _____

2ND

at 25dB	R	L	
500Hz			_ Pass
1000Hz			_ Fail
2000Hz			REFER
4000Hz			_____

Date _____

Signature

Signature

VISION SCREENING

DISTANCE ACUITY (1ST):
 R-20/ _____ L-20/ _____

_ Pass _ Fail
RESCREEN

DISTANCE ACUITY (2ND):
 R-20/ _____ L-20/ _____

_ Pass _ Fail
RESCREEN

Screened with glasses?

Screened with glasses?

_ Yes _ No

_ Yes _ No

_ Snellen Chart

_ Snellen Chart

_ Other

_ Other

Signature Date

Signature Date

PHYSICIAN'S VERIFICATION OF MEASLES/MUMPS ILLNESS

This is to verify that the child above had

___ measles illness on or about _____
month and year

___ mumps illness on or about _____
month and year

and does not need the vaccines(s).

Date Physician's Signature

HAS _____
(Child's Name)

- Had any recent illnesses? Yes No
If YES, please name: _____
- Had chronic illness/hospitalizations? Yes No
If YES, please describe: _____
- Had any allergies? Yes No
If YES, please list: _____
- Are there any parent concerns? Yes No
If YES, please describe: _____

PARENT/GUARDIAN'S SIGNATURE _____

I have examined the child named on this form and find that he/she is / is not able to participate in the school program (circle one)

PHYSICIAN'S SIGNATURE

DATE