Al-Hadi School *of* Accelerative Learning

2313 S. Voss Rd. Houston, Texas 77057 (713) 787-5000 ext. 2500 Fax (713)513-5315
Website: www.alhadi.com email: registrar@alhadi.com

HEALTH / MEDICAL INFORMATION FORM

School Year: _____ Grade: _____

To be completed by Parent or Guardian. Please Print.

Child's Name _____ Sex: M / F DOB: _____
First Middle Last Month Day Year

Address _____
Street City Zip Code

Father's Name _____ Telephone _____ _____
First Last Home Work

Mother's Name _____ Telephone _____ _____
First Last Home Work

List any special problems that your child may have, such as **allergies**, existing illness, previous serious illness, injuries, psychological or emotional difficulties during the past 12 months, any **medication** taken daily (over-the-counter or prescription), and any other information which the staff should be aware of:

_____

_____

_____

IMMUNIZATION RECORD

(See attached list of Texas requirements)

TO BE COMPLETED BY PHYSICIAN

	1	2	3	4	5	6	
DPT DPTaP DT							
Polio OPV, IPV							
HIB							
MMR							
Measles Only							
Hepatitis B							
Varicella							Or approx. date of varicella disease: _____ Complete documentation form on reverse side.
TB Skin Test *(Required for KG & Up)*							

(OVER)

DOCUMENTED HISTORY OF VARICELLA DISEASE

Please complete this section if your child has already had the Varicella disease (Chickenpox).

"This is to verify that _____ had Varicella disease (Chickenpox) on or about
(name of child)

_____ and does not need Varicella vaccine."
(date)

Parent/Guardian Signature: _____

Relationship to Student: _____ Date: _____

HEARING / VISION SCREENING

HEARING SCREENING 1ST

at 25dB	R	L
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		

☐ PASS ☐ FAIL

☐ RESCREEN

Signature: _____

Date: _____

HEARING SCREENING 2ND

at 25dB	R	L
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		

☐ PASS ☐ FAIL

☐ RESCREEN

Signature: _____

Date: _____

VISION SCREENING 1ST

DISTANCE ACUITY: R - 20/ _____ L – 20/ _____

☐ PASS ☐ FAIL

☐ RESCREEN Date: _____

Signature: _____

Date: _____

VISION SCREENING 2ND

DISTANCE ACUITY: R - 20/ _____ L – 20/ _____

☐ PASS ☐ FAIL

☐ RESCREEN Date: _____

Signature: _____

Date: _____

IMPORTANT: DOCTOR'S STATEMENT

"I find that the above-named child is physically able to take part in all physical activities of Al-Hadi School."

Exceptions: Last Exam Date: _____

_____

_____

Physician's Signature: _____ Date: _____