Al-Hadi School *of* Accelerative Learning

14855 Richmond Ave. Houston, Texas 77082 (832)617-8363. Fax (713)513-5315
Website: www.alhadi.com email: registrar@alhadi.com

HEALTH INFORMATION FORM

School Year: _____ Grade: _____

To be completed by Parent or Guardian. Please Print.

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

Address _____
Street City Zip Code

Name of Parent or Legal Guardian 1 _____ Phone: _____
First Last Home Work

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

☐ MEDICAL AUTHORIZATION

Name of Licensed Physician: _____

Address: _____

Telephone No: _____

☐ In the event my child has a temperature, and I cannot be reached, I authorize the supervising staff to administer (Tylenol) to my child

☐ In the event my child needs emergency medical treatment, and I cannot be reached, I authorize the supervising staff to take my child to the nearest hospital.

_____ _____
Signature of Parent Date

☐ MEDICAL INFORMATION ABOUT THE STUDENT

List any allergies or allergic reactions your child may have: Kindly attach the doctor's guidelines if the student reacts to the listed allergy

Is your child currently on any medication prescribed for long-term use or short-term use? If so, please list.

Please list below any chronic illnesses, physical disabilities or psychological conditions for which the applicant has been treated or has received medications or which would affect full participation in the scholastic and/or athletic programs of Al-Hadi School.

Name and address of the doctor treating the above condition.

_____ _____
Signature of Parent Date

Kindly attach the most updated Immunization Record and request your child's PCP office to complete the following portion of the form:

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: _____

VISION SCREENING 1ST

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

☐ PASS ☐ FAIL

☐ RESCREEN Date: _____

Signature: _____

VISION SCREENING 2ND

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

☐ PASS ☐ FAIL

☐ RESCREEN Date: _____

Signature: _____

Date:

SPINAL SCREENING

STUDENT SPINAL SCREENING					RESULTS OF REFERRALS PHYSICIAN DIAGNOSIS				RESULTS OF REFERRALS TREATMENT PLAN				
Grade (G) Age (A) Sex (F or M)	**Under Prior Treatment** (Do not screen)	**Screened**	**Rescreened**	**Referred**	**Normal**	**Scoliosis**	**Kyphosis**	**Other**	**Observation Only**	**Orthosis Bracing**	**Operation Surgery**	**Other**	**Results Unavailable**
G5F													
G7F													
G8M													
A10F													
A12F													
A13M													
A14M													

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