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

IMMUNIZATION RECORD
(See attached list of Texas requirements)

		1	2	3	4	5	6	Signature needed
TO BE COMPLETED BY PHYSICIAN	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: WELL CHILD STATEMENT

List any special problems that the above mentioned patient 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:

_____

_____

This is to certify that the above named individual has been examined by me on _____
and found to be in good health and able to attend school, as well as participate in age appropriate physical activities.

Physician's Signature: _____ Date: _____