# 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

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 | Signature needed |
|---|---|---|---|---|---|---|---|
| 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

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.

Exceptions:

_____

Physician's Signature: _____ Date: _____