

TEXAS CENTER FOR ARTS + ACADEMICS MEDICAL CERTIFICATE (REQUIRED ANNUALLY)

**RETURN
BOTH PAGES**

This Section to be completed by Parent/Guardian

Student Name _____ Date of Birth _____ Grade in Fall _____
Last First Middle Month / Day / Year

Address _____ Home Telephone (_____) _____
Street City Zip Please include area code with all phone numbers

Parent/Guardian _____ Work Phone (_____) _____ Cell Phone (_____) _____

Parent/Guardian _____ Work Phone (_____) _____ Cell Phone (_____) _____

1. Immunization: A Copy of Immunization Record is required each year. Must indicate the Month, Day & Year of Series and Boosters as required by Texas Department of Health. All immunizations must be current or attendance will be denied.

2. Health History: Today's Date _____

Food Allergies _____ Drug Allergies _____

Environmental Allergies _____ Asthma _____

Heart Conditions _____ Seizure Disorder _____

Orthopedic Conditions _____ Diabetes _____

Emotional/Psychological/Behavioral Concerns _____

Attention Deficit _____ Bed Wetting _____

Other _____

Previous Injuries, Illnesses, Surgeries _____

List all medications taken for the above conditions: _____

This is to verify that _____ had varicella disease (chickenpox) on or about _____ and does not need the varicella vaccine. month/day/year

This student may be administered the following medications (or their generic equivalent) during the school day:
 ___Ibuprofen ___Acetaminophen ___Antibiotic Cream ___Diphenhydramine Cream **Parent Signature:** _____

This section to be completed by Physician

3. Physical Examination: Date _____ (Must be within 3 months prior to start of new school year)

Height _____ Weight _____ Blood Pressure _____ Vision: Right _____ Left _____

	Negative	Positive		Negative	Positive
Skin	_____	_____	Abdomen	_____	_____
Head	_____	_____	Genitalia	_____	_____
Eyes, Ears, Nose	_____	_____	Extremities	_____	_____
Mouth, Throat	_____	_____	Joint Function	_____	_____
Neck	_____	_____	Spine-Scoliosis	_____	_____
Lungs and Chest	_____	_____	Kyphosis	_____	_____
Heart	_____	_____	Lordosis	_____	_____
Hearing	_____	_____	Vision	_____	_____

Date of first menstrual period _____ Date of last menstrual period _____

Explain any abnormal findings: _____
 I certify that on this date I have examined the above student as indicated by items checked, and I recommend him as being physically able to participate in those supervised activities checked below:

_____Trips _____Campouts _____All Sports _____Swimming _____Exceptions (List) _____

(_____) _____
 Area Code Phone

Printed Name of Physician _____ Signature of Examining Physician _____

TRAVEL/MEDICAL RELEASE/PARENTAL AUTHORIZATION FORM: RETURN AT OPEN HOUSE

Student Name _____ **Grade** _____

A. Authorization to Consent to Medical Treatment: In the event my child becomes ill or injured at school related events and I cannot be reached, Texas Center for Arts + Academics (TXCAA) is authorized to take one or more of the following actions: a) release my child to either of the people listed below: b) take my child to the physician chosen by choir / school staff; or c) take my child to a hospital and give consent for emergency care.

Local emergency telephone numbers if parents cannot be reached at above numbers:

Name _____ Telephone (_____) _____ Relationship _____

Name _____ Telephone (_____) _____ Relationship _____

Doctor's Name _____ Office Phone (_____) _____

Preferred Hospital _____ Telephone (_____) _____

Student is covered by:

Insurance Company _____ Certificate Number _____

Name of Insured _____ Insured's Employer _____

TXCAA is not financially responsible for emergency care or transportation.

B. Release and Authorization to Participate in Physical Education and Approved Travel:

I give my consent for my child to participate in TXCAA approved sports as listed on the Medical Certificate, extra-curricular activities, and approved travel with transportation being provided by the staff, paid carriers, other representatives of the school, or any parent. I understand that by participating in physical education and athletics at TXCAA my child will be exposed to the risk of serious injury, including but not limited to injuries such as sprains and fractures, and injuries that could result in brain damage, paralysis or even death. I understand that contact sports have a higher risk factor than other sports. I understand that TXCAA does not assume any responsibility in case an accident occurs. In consideration for my child being permitted to take part in such activities and to make such trips, I HEREBY WAIVE ALL CLAIMS, AND I RELEASE, INDEMNIFY, DEFEND AND HOLD HARMLESS TXCAA, their Board of Directors, Officers, President & CEO, Directors, Administrators, faculty, staff, employees, agents, and invitees together with all persons, including parents of students of TXCAA assisting with any phase of such activities and trips (excluding paid certified carriers), from any and all liability claims, suits, demands or causes of action, including all expenses of litigation and/or settlement, which may arise in connection with such activities and trips, including any accident or injury suffered by my child while involved in such activities and trips.

C. This section applies to off campus extended overnight travel ONLY.

Authorization of Administration of Medication in the event of extended sponsored activities: I give my consent for my child to be administered (per packaging directions) the following non-prescription medication(s) or its generic equivalent by the school staff, athletic director, or President & CEO designee(s):

YES NO

- ____ Acetaminophen 500mg tabs, 1 or 2 tabs PO Q4h PRN headache or fever X 1 year
- ____ Ibuprofen 200 mg tabs, PO Q4h PRN strain, sprain, muscle aches or pains, menstrual cramps, or dental pain X 1 year
- ____ Hydrogen Peroxide, followed by triple antibiotic ointment and a Band-Aid daily until healed PRN minor cuts and abrasions X 1 year
- ____ Diphenhydramine 25 mg cap, 1 PO Q4-6h PRN allergic reaction X 1 year
- ____ Aluminum Hydroxide Magnesium Hydroxide & Simethicone, 2 teaspoons QID PRN upset stomach, indigestion, or nausea X 1 year
- ____ Dextromethorphan cough syrup, 2 teaspoons Q4h PRN cough X 1 year
- ____ Pseudoephedrine 30 mg tabs, 2 tabs PO QID PRN nasal congestion X 1 year
- ____ Calamine lotion applied to affected areas PRN heat rash or insect bites X 1 year
- ____ Sunscreen SPF 25-30 PRN applied to exposed skin for prolonged exposure to sun X 1 year
- ____ Cough Drops PRN sore throat X 1 year
- ____ Aloe Vera Gel PRN sunburn or other minor skin irritations X 1 year
- ____ Anti-Diarrheal – Loperamide HCl 2 mg. Softgel Cap
- ____ Anti-gas - Gas-X, Simethicone 125 mg.
- ____ Calcium Carbonate USP 750 mg.
- ____ Stool Softener – Docusate Sodium 100 mg.
- ____ Loratadine (Claritin) 10 mg.
- ____ Swimmer's Ear - Drops

Other medications or prescription medication which may be required by the student during school related or extended travel must be supplied by the parents and turned in the original container, properly labeled, with the name of the student and identification of the medication, the dosage, and the time to be administered by the school staff or the President & CEO's designee.

(Separate form required –please see Request for Administration of Medication)

NOTARIZATION REQUIRED

Subscribed and sworn before me, on this the _____ day of _____, 201_____.

Signature of Parent

Signature of Notary

Date Commission Expires