

THE EMERY/WEINER SCHOOL
9825 Stella Link Road
Houston, TX 77025
(832) 204-5900 (713) 981-0995 FAX

HEALTH CERTIFICATE AND PHYSICIAN'S REPORT

2009 - 2010

In accordance with the State of Texas and Harris County, the Health Certificate/Physician's Report and Immunization Record must be completed and submitted to the school office prior to August 7, 2009. All vaccines, tests, and screenings must be completed as indicated below.

Any student that does not have a current and completed Health Certificate/Physician's Report and Immunization Record on file in the school office and will NOT be allowed to start school.

STUDENT NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ PHONE: _____

IMMUNIZATION REQUIREMENT FOR STUDENTS OF TEXAS
SCHOOL AND INSTITUTIONS OF HIGHER EDUCATION

Please attach a copy of the complete Immunization Record for your child. The Department of Health requires full dates for all immunizations (Mo-Day-Yr). Failure to provide complete information could result in your child not being able to enter school.

Other pertinent information related to the health of student (i.e. allergies, existing illness, previous serious illness, and injuries during the past 12 months):

Allergies to bee stings, grass, pollen, etc. Identify, describe reaction and recommended course of action to be taken by staff:

Is student on any medications (long-term or short-term)? Yes ___ No ___ If yes, specify drug and dosage:

Other information for our attention.

PHYSICAL EDUCATION DEPT AND COMPETITIVE SPORTS
PHYSICAL EXAMINATION FORM

Parent or Guardian's Permit

I hereby give my consent for the above student to participate in competitive sports. My child has permission to leave the school premises with the coach or other school representatives to participate in sporting events. I also herewith grant permission for school employees to secure medical services for the above named student if necessary.

Parent's Signature: _____ Date: _____

I further certify that he/she may compete in the following competitive sports programs:

Basketball: _____ Soccer: _____ Volleyball: _____ Track: _____
No sports: _____

Special instructions or limitations:

PHYSICIAN'S REPORT

Height: _____ Weight: _____ Body Type (maturation status): _____
Pulse: _____ Blood Pressure: _____ Lungs: _____

Joint function - any noted laxities:

Shoulders: _____ Elbows: _____ Hips: _____ Knees: _____
Wrists: _____ Ankles: _____ Feet: _____ Hands: _____

Hernia: _____

Scoliosis Screening: _____ Results: _____

Audiometric Screening: _____ Results: _____

Visual Screening: _____ Normal: _____ Results: _____

Acanthosis Nigricans _____ **this is required for all seventh grade students.**

Has student ever had any of the following? Allergies to medication, head injury, unconsciousness, bone or joint disease and/or injury, heart disease, previous surgeries, hypertension, diabetes, emotional disturbance, epilepsy? If yes, please explain:

I certify that I have examined the above-named student as indicated and recommend him/her as being physically able or physically unable to participate in physical education classes.

Physician's name (please print)

Address

Physician's signature

Telephone

State License

Date

EMERGENCY PROCEDURE FORM

Date _____

Grade _____

Student's Name _____

Home Telephone Number _____

Address _____

List Allergies/Health Problems

In case of emergency, illness or accident to the above-named student, the school is authorized to proceed as indicated. Please list all numbers.

_____ Contact Father/Guardian at

(Telephone numbers)

_____ Contact Mother/Guardian at

(Telephone numbers)

_____ Contacts Grandparents at

(Telephone numbers)

_____ Contacts Friend/Relative at

(Name, relation to student, and telephone #'s)

_____ Contacts Family Physician

(Physician name and telephone)

_____ Take child to emergency hospital

(Hospital name and telephone)

Please list additional cellular and/or pager numbers below:

E-mail address for Parent(s): _____

Grade _____

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PERMISSION FOR ADMINISTRATION OF FEVER/PAIN RELIEF MEDICATION

STUDENT NAME: _____ DATE OF BIRTH: _____

In order to keep your child in optimum health and to help maintain school performance, it may be necessary to administer fever or pain medication to your child during school hours. Please indicate below the medication(s) and dosage for us to administer to your child.

Name of medication(s): _____

Form of medication to be given (circle below):

Tablet/Pill/Capsule Inhalation Liquid Injection Other _____

Dosage (amount to be given) _____

Please indicate how often _____ or as needed _____
(Injections will not be given except in extreme emergency, such as allergy to bee, etc.)

Emery/Weiner has permission to administer medication to my child named above. I understand that by law all medications must be turned into the school office for storage and administering.

The complete form should be signed and returned to the school office prior to the first day of school.

Parent's Signature

Parent's Telephone #

Date

Grade _____

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PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION AT SCHOOL DURING SCHOOL HOURS

STUDENT NAME: _____ DATE OF BIRTH: _____

In order to keep your child optimum health and to help maintain school performance, it is necessary that medication be administered during school hours. **Should a physician prescribe medication, this form must be completed and returned to Emery/Weiner prior to the first day of school. Physician's signature is required for all prescribed medications.**

Name of medication(s):

Form of medication to be given (circle below):

Tablet/Pill/Capsule Inhalation Liquid Injection Other _____

Dosage (amount to be given) _____

How often or at what time _____

(Injections will **not** be given except in **extreme** emergency, such as allergy to bee, etc.)

Common side effects _____

Remarks

Physician's Signature

Physician's Telephone #

This is my permission to administer medication to my child named above as requested by the physician.

Parent's Signature

Parent's Telephone #

Date