



Medical History Form

2026-2027

2501 Northshore Blvd.
 Flower Mound, TX 75028
 Phone: 972-539-1298
 Fax: 972-539-4649
 www.templebc.org
 www.tclctx.com

It is mandatory that students who show symptoms of a communicable disease be excluded from classes until re-admission is acceptable to the school administration. Your cooperation is greatly appreciated.

Student's Name: _____ Birthdate: _____ Sex: F M

Home #: _____ Father's Work #: _____ Mother's Work #: _____

PAST DISEASES
 (If your child has had any of the following, please state the age when he/she had them.)

Measles _____	Diphtheria _____	Polio _____
Mumps _____	Scarlet Fever _____	Convulsions _____
Whooping Cough _____	Rheumatic Fever _____	Heart Disease _____
Asthma _____	Chicken Pox _____	Discharging Ears _____
Flu _____	Diabetes _____	
Hay Fever _____	Pneumonia _____	

RECENT DISABILITIES
 (Please check all that are applicable.)

<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Hearing Difficulty
<input type="checkbox"/> Frequent Sore Throat	<input type="checkbox"/> Abdominal Pains	<input type="checkbox"/> Tires Easily
<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Breath Shortness
<input type="checkbox"/> Frequent Leg Pain	<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Hernia (rupture)
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Ringworm
<input type="checkbox"/> Frequent Sties	<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Dental Defects	<input type="checkbox"/> Crippling Conditions	

PERSONAL RECORD
 (Please answer all of the following.)

<input type="checkbox"/> Yes <input type="checkbox"/> No Is He/She Shy	<input type="checkbox"/> Yes <input type="checkbox"/> No Overactive	<input type="checkbox"/> Yes <input type="checkbox"/> No Bites Fingernails
<input type="checkbox"/> Yes <input type="checkbox"/> No Sucks Thumb	<input type="checkbox"/> Yes <input type="checkbox"/> No Has Excessive Fears	<input type="checkbox"/> Yes <input type="checkbox"/> No Has Temper Tantrums
<input type="checkbox"/> Yes <input type="checkbox"/> No Like School	<input type="checkbox"/> Yes <input type="checkbox"/> No Plays Well With Others	<input type="checkbox"/> Yes <input type="checkbox"/> No Eats Breakfast
<input type="checkbox"/> Yes <input type="checkbox"/> No Immunizations to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No Immunization Records Attached	
<input type="checkbox"/> Yes <input type="checkbox"/> No Free from Communicable Diseases	If no, explain . _____	

Existing Illness _____ Previous serious Illness _____ Other _____

Injuries and hospitalizations (past 12 mos) _____ Limitations/restrictions on child's activities _____

Reasonable accommodations/modifications _____ Adaptive equipment _____

Symptoms /indications of complications _____ (include instructions for equipment)

Medications prescribed for continuous long-term use _____

Explain any needs selected above _____

Does your child have allergies? Food Bee or Insect Stings Drugs Other (If you marked Food or Stings, please complete the Allergy Action Plan Form) If any marked, please explain: _____

MEDICATION

Is the applicant on any medication? Yes No *(If yes, and medication must be administered by the Learning Center Director, please also read the Medication Policy and attach the Medication Disbursement Form.)*

What kind? _____ **How often?** _____

EMERGENCIES

Child's Physician: _____ Phone: _____

Physician's Address: _____

Insurance Company: _____ Policy #: _____

PERSON TO BE NOTIFIED (OTHER THAN PARENT(S)/GUARDIAN(S) IN AN EMERGENCY.

Name: _____ Phone: _____

AUTHORIZATION FOR MEDICAL TREATMENT:

I HEREBY AUTHORIZE MEDICAL PERSONNEL AND/OR HOSPITAL EMERGENCY STAFF TO ADMINISTER ANY EMERGENCY TREATMENT, PROCEDURE, OR MEDICINE NECESSARY WHEN TEMPLE CHRISTIAN LEARNING CENTER PERSONNEL ACCOMPANY (CHILD'S FULL NAME) _____ TO THE EMERGENCY ROOM. I ALSO AUTHORIZE TEMPLE CHRISTIAN LEARNING CENTER PERSONNEL TO SECURE THE USE OF AN AMBULANCE IF NECESSARY. I AGREE TO PAY THE HOSPITAL, DOCTORS, AND AMBULANCE SERVICE FOR ALL SERVICES RENDERED TO THE ABOVE PATIENT.

IF YOU DO NOT GIVE PERMISSION OR AUTHORIZATION TO GIVE CONSENT FOR MEDICAL TREATMENT, WHAT PROCEDURE SHOULD BE FOLLOWED?

SIGNED: _____ DATE: _____
 PARENT OR GUARDIAN

RELEASE OF LIABILITY:

I ABSOLVE TEMPLE CHRISTIAN LEARNING CENTER FROM ANY LIABILITY TO MY CHILD BECAUSE OF AN INJURY TO MY CHILD WHILE AT TEMPLE CHRISTIAN LEARNING CENTER, ANY LEARNING CENTER-SPONSORED ACTIVITY, SPORTS PRACTICE OR SPORTS GAME SPONSORED BY TEMPLE CHRISTIAN LEARNING CENTER.

SIGNED: _____ DATE: _____
 FATHER'S SIGNATURE

SIGNED: _____ DATE: _____
 MOTHER'S SIGNATURE

CERTIFICATION:

I DO HEREBY CERTIFY THAT ALL OF THE INFORMATION CONTAINED WITHIN THIS DOCUMENT IS CORRECT AS OF THE DATE SIGNED.

SIGNED: _____ DATE: _____
 PARENT OR GUARDIAN

IMMUNIZATION RECORD

- I have provided Temple Christian Learning Center a copy of my child's most current immunization record.
- I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit from developed and issued by the Department of State Health Services. I understand that this affidavit is valid for two (2) years.

**HEALTH CARE PROFESSIONAL'S STATEMENT
(Requirement of Admission)**

If your child does not attend pre-kindergarten or school away from Temple Christian Learning Center, one of the following must be presented when your child is admitted to Temple Christian Learning Center or within one (1) week of admission.

- Health Care Professional's Statement: I have examined the above named child within the past year and find that he/she is able to take part in the day care program.

_____ **Health Care Professional's Signature (M.D. or Nurse Practitioner)**

_____ **Date**

- A signed and dated copy of a health care professional's statement is attached.
- Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

VISION AND HEARING SCREENING (4 YEAR OLDS ONLY)

Vision	R 20/ _____	L 20/ _____	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Signature _____		Date _____	

Hearing	1000 Hz	2000 Hz	4000 Hz	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
R				
L				
Signature _____		Date _____		

_____ Parent of Legal Guardian's Signature

_____ Date