



ROUND ROCK CHRISTIAN ACADEMY

New Student Medical Forms

Early Childhood (MDO, Preschool, PreKindergarten)

First Aid / Medication Permit

Please indicate your approval for the following first aid treatment and medications:

- Yes No **First aid care for minor cuts, rashes, insect bites**—Hydrogen peroxide, soap, and water or alcohol, Bacitracin, aloe vera gel, calamine lotion, anti-itch ointments, bandages as needed.
- Yes No **Cough drops** as deemed necessary by the teacher or the nurse.
- Yes No Acetaminophen (Tylenol) is administered with discretion by the nurse. (**All** other medications **must** be brought to the school nurse and administered by the nurse.)
- Yes No Parent requires prior notification before Tylenol is administered.
- Yes No **I will provide a current copy of the student's IMMUNIZATION RECORD to RRCA 30 DAYS of enrollment.**

Student Name: _____ DOB: _____ Grade: _____

Parent/Guardian Signature: _____ Date : _____



ROUND ROCK CHRISTIAN ACADEMY

Early Childhood Health Statement

Student's Name: _____

Date of Birth: _____

Name and Address of Doctor / Clinic: _____

The above child has been examined by a licensed physician within the last year, or has been examined in a clinic or health program. The child is physically able to take part in the school program.

Date Examined: _____

Signature of Physician or Health Personnel: _____

Date Signed: _____

Diagnosed Medical Conditions: (Asthma, Allergies, etc.)

**A CURRENT COPY OF THE IMMUNIZATION RECORD IS REQUIRED
and MUST BE ON FILE WITHIN 30 DAYS OF ENROLLMENT.**

ROUND ROCK CHRISTIAN ACADEMY

301-A N. Lake Creek Drive

Round Rock, TX 78681

Fax (512) 255-6043



ROUND ROCK CHRISTIAN ACADEMY

Health History

The information requested on this form is to provide a more accurate and up-to-date medical record for your child. Our desire is to give your child the best possible learning environment and this information will assist us in that endeavor.

Name of Child: _____ DOB: _____

Name of Parent/Guardian: _____

Disease History

	Yes	No		Yes	No
Asthma	___	___	Headaches	___	___
Heart Disease	___	___	Epilepsy	___	___
Tuberculosis	___	___	Frequent Colds	___	___
Hypertension	___	___	Ear Infections	___	___
Rheumatic Fever	___	___	Sore Throats	___	___
Blood Disorders	___	___	Chronic Disease	___	___
Kidney Disorders	___	___	Cancer	___	___
Diarrhea, Constipation	___	___	Diabetes	___	___
Ulcers	___	___	Allergies	___	___
Arthritis	___	___	Scoliosis	___	___
Skin Rashes	___	___			

If yes on any of the above, please explain: _____

Any other medical concerns: _____

Does your child use an inhaler or nebulizer?_____ If yes, how often? _____

Does your child have an **EPI PEN**? _____

Hospitalizations: _____

Current Medications (Prescription and Over the Counter): _____



ROUND ROCK CHRISTIAN ACADEMY

Vision and Hearing Screening

Student's Name: _____ Date of Birth: _____

Screeener's name: _____ Screening Date: _____

VISION SCREENING

<p style="text-align: center;">Distance Acuity Screen</p> <p>First screen: Date: _____</p> <p>With correction: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chart Used:</p> <p><input type="checkbox"/> Letter Right eye 20/ <input type="checkbox"/> "E" Left eye 20/ <input type="checkbox"/> H:O:T:V <input type="checkbox"/> Machine <input type="checkbox"/> Pass <input type="checkbox"/> Fail</p>	<p>Second screen:</p> <p>With correction: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chart Used:</p> <p><input type="checkbox"/> Letter Right eye 20/ <input type="checkbox"/> "E" Left eye 20/ <input type="checkbox"/> H:O:T:V <input type="checkbox"/> Machine <input type="checkbox"/> Pass <input type="checkbox"/> Fail</p>	<p>Comments/Observations:</p>
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HEARING SCREENING
Sweep-Check Screening

1. Instruct and condition each child appropriately for age/grade.
2. Screen 3 frequencies @ 25 dB HL; begin screening @ 1000 Hz.
3. Identify responses with a "+"; identifying no response with a "-".
4. Sequence of tone presentations is numbered 1-3 below.

	Ear	1000 Hz	2000 Hz	4000 Hz	Results
First Screen	R				____ Pass
Date: _____	L				____ Rescreen w/ sweep check