ROUND ROCK CHRISTIAN ACADEMY

New Student Medical Forms

Early Childhood (Preschool and 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
800 Westwood 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: _____

Screener's name: _____ Screening Date: _____

VISION SCREENING

Distance Acuity Screen		Comments/Observations:
First screen: Date: _____	**Second screen:**	
With correction: ❑ Yes ❑ No	With correction: ❑ Yes ❑ No	
Chart Used: ❑ Letter Right eye 20/ ❑ "E" Left eye 20/ ❑ H:O:T:V ❑ Machine ❑ Pass ❑ Fail	Chart Used: ❑ Letter Right eye 20/ ❑ "E" Left eye 20/ ❑ H:O:T:V ❑ Machine ❑ Pass ❑ Fail	

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