ROUND ROCK CHRISTIAN ACADEMY

New Student Medical Forms

Kindergarten-12th Grades

Statement of Health

❑ **Yes** ❑ **No** My child is in good health and is physically able to participate in all school programs and activities. IF THERE ARE ANY EXCEPTIONS, I understand that a signed statement by a physician must accompany this form and be on file WITHIN 30 DAYS OF ENROLLMENT.

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

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, Hearing, Scoliosis Screening

Student's Name: ______________________________ Date of Birth: ______________________

Screener's name: ______________________________ Screening Date: _____________________

VISION SCREENING

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

SPINAL SCREENING
5TH—7TH GRADE ONLY

____ Normal spinal screening.

____ The following variations were found during the screening:

L	R		L	R	
❑	❑	High shoulder	❑	❑	One side of back higher than the other side when bending forward
❑	❑	Shoulder blade stands out	❑	❑	Hip higher than the other
❑	❑	Asymmetrical waist	❑	❑	Obvious curve of the spine
❑	❑	Asymmetrical waist	❑	❑	Obvious curve of the spine