2007 McCall Road · Austin, Texas 78703
512-478-7827 (Office) • 512-478-5456 (Fax) • www.thegirlsschool.org

Student Health Form (2020-2021)

Parents must complete page 1 of this form. Please have your physician complete and sign page 2. Thank you!

Parent Acknowledgement

The Student Health Form, completed and signed by your physician, indicating that your child has been examined within the calendar year and has been cleared to participate in school programs/activities, and a copy of your child's Immunization Record are required *prior to enrollment* and must be submitted to the school office by ***Friday, August 7 2020.*** If these documents are not received prior to this date, your daughter may not start school until these requirements have been satisfied with our office.

State health regulations also require Vision/Hearing/Spinal screenings. These screenings are offered at the school by an outside provider at a nominal fee. If performed by your child's physician or other health provider, please submit a copy of the exam results to the school or have the physician and/or provider complete and sign page 2 of this form.

Immunization Record: As stated above, a copy of your child's immunization record must be provided to the GSA Office. Please review the immunization requirements published by the Health Department, and if necessary, also check with your medical provider, to ensure that your daughter is up to date on all her immunizations. If for some medical reason, your daughter cannot receive a specific vaccine, a medical exception signed by your physician, or if you have a conscientious objection for specific immunizations, an official notarized affidavit, must be filed with our office prior to enrollment.

My daughter's immunization records are: ☐ Attached ☐ On File w/GSA*

*If on file, you are certifying that there have been no changes to your daughter's immunization records and the record on file is up-to-date and complete with all required immunizations, or the appropriate affidavit/exception form is on file with the school.

Student Information (Please be sure to complete all information specified below):

Student Name: _____ Date of Birth: _____ Age: _____ Grade:_____

Please list any medical conditions, communicable diseases, serious illnesses, injuries this child has had in the past few years:

_____

Allergies (Please specify any food/drug/environmental allergies): _____

Medications: _____

Physician Information

Physician Info: _____ _____ _____

Physician Name Address Phone

Preferred Hospital Facility/Address: _____

_____ _____

Parent Signature Date

PHYSICIAN TO COMPLETE PAGE 2 ON REVERSE SIDE OF FORM → → → →

THE girls' SCHOOL OF AUSTIN
A PRIVATE SCHOOL FOR GIRLS K-8

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Student Health Form (2020-2021)

Page 2 to be Completed and Signed by Physician:

Physician Statement:

Name of Physician/Provider: _____ Address: _____ Phone: _____

Child's Name: _____ Date of Birth: _____ Age: _____

The above name child was examined in our office on _____ and has been cleared and is physically able to participate in all school programs/activities.

_____ _____
Signature of Physician Date Signed

Vision Screening

This is a basic screening test that indicates common visual abnormalities and is not a substitute for a complete eye exam. If there is a family history of vision problems, it is advised that your child's vision be screened yearly. Please provide specific results:

DISTANCE ACUITY:	**R _____**	**L_____**
MUSCLE BALANCE:	PASS	FAIL
FARSIGHTED LENS:	PASS	FAIL
CHART USED:	Snellen	HOTV
CORRECTIVE LENS WORN:	YES	NO

____ This is a normal test for this student's age.
____ Failed screening. This student needs a complete eye exam within the next 2-3 weeks. Results of re-exam should be sent to the school upon completion.

Signature of Provider: _____
Date Screened: _____

Hearing Screening

This is a basic screening test that identifies a hearing loss that may affect daily activities.

At 25 db	R	L
1000 Hz	____	____
2000 Hz	____	____
4000 Hz	____	____

____ This is a normal test.
____ Failed screening. This student needs a complete ear exam preferably within the next 24-48 hours. Results of re-exam should be sent to the school upon completion.

Signature of Provider: _____
Date Screened: _____

Spinal Screening

If a spinal screening is required (as indicated above), results of the exam must be indicated below or attached to this form. If there is a family history of scoliosis, it is advised that your child's spine be checked yearly.

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 spine

____ Normal spinal screening
____ The following variations were found during the screening: _____

Signature of Provider: _____ Date Screened: _____