TEXAS CENTER FOR ARTS + ACADEMICS
MEDICAL CERTIFICATE (REQUIRED ANNUALLY)

RETURN AT OPEN HOUSE

This Section to be completed by Parent/Guardian

Student Name_____ Date of Birth_____ Grade in Fall _____
Last First Middle Month / Day / Year

Address_____ Home Telephone (_____)_____
Street City Zip Please include area code with all phone numbers

Parent/Guardian_____ Work Phone (_____)_____ Cell Phone (_____) _____

Parent/Guardian _____ Work Phone (_____)_____ Cell Phone (_____) _____

1. Immunizations: A Copy of Immunization Record is required each year. Must indicate the Month, Day & Year of Series and Boosters as required by Texas Department of Health. All immunizations must be current or attendance will be denied.

2. Health History: Today's Date _____

Food Allergies_____ Drug Allergies _____
Environmental Allergies_____ Asthma _____
Heart Conditions_____ Seizure Disorder _____
Orthopedic Conditions_____ Diabetes _____
Emotional/Psychological/Behavioral Concerns _____
Attention Deficit_____ Bed Wetting _____
Other _____
Previous Injuries, Illnesses, Surgeries _____
List all medications taken for the above conditions:_____

_____

This is to verify that _____ had varicella disease (chickenpox) on or about _____ and does not need the varicella vaccine. month/day/year

This student may be administered the following medications (or their generic equivalent) during the school day:
_____Advil _____Tylenol _____Neosporin _____Benadryl Cream **Parent Signature:**_____

This section to be completed by Physician

3. Physical Examination: Date_____(Must be within 3 months prior to start of new school year)

Height_____Weight _____ Blood Pressure _____ Vision: Right_____Left _____

	Negative	Positive		Negative	Positive
Skin	_____	_____	Abdomen	_____	_____
Head	_____	_____	Genitalia	_____	_____
Eyes, Ears, Nose	_____	_____	Extremities	_____	_____
Mouth, Throat	_____	_____	Joint Function	_____	_____
Neck	_____	_____	Spine-Scoliosis	_____	_____
Lungs and Chest	_____	_____	Kyphosis	_____	_____
Heart	_____	_____	Lordosis	_____	_____
Hearing	_____	_____	Vision	_____	_____

Date of first menstrual period _____ Date of last menstrual period_____

Explain any abnormal findings:_____
I certify that on this date I have examined the above student as indicated by items checked, and I recommend him as being physically able to participate in those supervised activities checked below:
_____Trips _____ Campouts _____All Sports _____Swimming _____Exceptions (List) _____

(_____)_____
Area Code Phone

_____ _____
Printed Name of Physician Signature of Examining Physician

Revised 04.27.2017

TRAVEL / MEDICAL RELEASE / PARENTAL AUTHORIZATION FORM

Student Name_____**Grade**_____

A. Authorization to Consent to Medical Treatment: In the event my child becomes ill or injured at school related events and I cannot be reached, Texas Center for Arts + Academics (TXCAA) is authorized to take one or more of the following actions: a) release my child to either of the people listed below: b) take my child to the physician chosen by choir / school staff; or c) take my child to a hospital and give consent for emergency care.

Local emergency telephone numbers if parents cannot be reached at above numbers:

Name_____Telephone (_____)_____Relationship _____

Name_____Telephone (_____)_____Relationship _____

Doctor's Name_____Office Phone (_____) _____

Preferred Hospital_____Telephone (_____)_____

Student is covered by:

Insurance Company_____Certificate Number_____

Name of Insured_____Insured's Employer_____

TXCAA is not financially responsible for emergency care or transportation.

B. Release and Authorization to Participate in Physical Education and Approved Travel:

I give my consent for my child to participate in TXCAA approved sports as listed on the Medical Certificate, extra-curricular activities, and approved travel with transportation being provided by the staff, paid carriers, other representatives of the school, or any parent. I understand that by participating in physical education and athletics at TXCAA my child will be exposed to the risk of serious injury, including but not limited to injuries such as sprains and fractures, and injuries that could result in brain damage, paralysis or even death. I understand that contact sports have a higher risk factor than other sports. I understand that TXCAA does not assume any responsibility in case an accident occurs. In consideration for my child being permitted to take part in such activities and to make such trips, I HEREBY WAIVE ALL CLAIMS, AND I RELEASE, INDEMNIFY, DEFEND AND HOLD HARMLESS TXCAA, their Board of Directors, Officers, President & CEO, Directors, Administrators, faculty, staff, employees, agents, and invitees together with all persons, including parents of students of TXCAA assisting with any phase of such activities and trips (excluding paid certified carriers), from any and all liability claims, suits, demands or causes of action, including all expenses of litigation and/or settlement, which may arise in connection with such activities and trips, including any accident or injury suffered by my child while involved in such activities and trips.

C. This section applies to off campus extended overnight travel ONLY.

Authorization of Administration of Medication in the event of extended sponsored activities: I give my consent for my child to be administered (per packaging directions) the following non-prescription medications(s) or its generic equivalent by the school staff, athletic director, or President & CEO designee(s):

YES	NO	
_____	_____	Tylenol 500mg tabs, 1 or 2 tabs PO Q4h PRN headache or fever X 1 year
_____	_____	Advil 200 mg tabs, PO Q4h PRN strain, sprain, muscle aches or pains, menstrual cramps, or dental pain X 1 year
_____	_____	Hydrogen Peroxide, followed by triple antibiotic ointment and a band-aid daily until healed PRN minor cuts and abrasions X 1 year
_____	_____	Benadryl 25 mg cap, 1 PO Q4-6h PRN allergic reaction X 1 year
_____	_____	Maalox, 2 teaspoons QID PRN upset stomach, indigestion, or nausea X 1 year
_____	_____	Robitussin DM cough syrup, 2 teaspoons Q4h PRN cough X 1 year
_____	_____	Sudafed 30 mg tabs, 2 tabs PO QID PRN nasal congestion X 1 year
_____	_____	Calamine lotion applied to affected areas PRN heat rash or insect bites X 1 year
_____	_____	Sunscreen SPF 25-30 PRN applied to exposed skin for prolonged exposure to sun X 1 year
_____	_____	Ricola lozenges PRN sore throat X 1 year
_____	_____	Aloe Vera Gel PRN sunburn or other minor skin irritations X 1 year
_____	_____	Anti-Diarrheal – Loperamide HCI 2 mg. Softgel Cap
_____	_____	Antigas - Gas-X, Simethicon 125 mg.
_____	_____	Calcium Carbonate USP 750 mg.
_____	_____	Stool Softener – Docusate Sodium 100 mg.
_____	_____	Loratadine (Claritin) 10 mg.
_____	_____	Swimmer's Ear - Drops

Other medications or prescription medication which may be required by the student during school related or extended travel must be supplied by the parents and turned it in the original container, properly labeled, with the name of the student and identification of the medication, the dosage, and the time to be administered by the school staff or the President & CEO's designee.

(Separate form required –please see Request for Administration of Medication)

NOTARIZATION REQUIRED

Subscribed and sworn before me, on this the

_____ day of _____, 201_____.

_____

Signature of Parent

_____ _____

Signature of Notary Date Commission Expires

Revised 04.27.2017