IMMUNIZATIONS (list or attach a copy of the child's immunization record)	Date/ Dose 1	Date/ Dose 2	Date/ Dose 3	Date/ Dose 4	Date/ Booster	Doses required
DTP/ DTaP/ DT/Td/Tdap						
Polio/ IPV/OPV						
MMR						
Pneumococcal PCV						
Meningococcal						
Hib						
Hepatitis A						
Hepatitis B						
Rotavirus						
Influenza						
Varicella **						

TB Test **Date Read** _____ **Positive** _____ **Negative** _____

** *Varicella (Chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella (chickenpox) disease on or about* _____ *and does not need varicella vaccine.*
date

_____ _____
Parent or Legal Guardian's Signature Date

_____ **I am excluding my child from the immunization requirements for reasons of conscience including religious belief. I have attached an official notarized affidavit form issued by the State Department of Health Services. I understand this affidavit is valid for 2 years.**

Hearing Screen	R	L	P/ F/ re-screen	Hearing Re-screen	R	L	P/ F/ refer	Vision Screen	P/ F / re-screen	Vision Re-screen	P/F / refer
@ 25 dB				@ 25 dB				Acuity		Acuity	
1000 Hz				1000 Hz				R – 20/		R – 20/	
2000 Hz				2000 Hz				L – 20/		L – 20/	
4000 Hz				4000 Hz							
Signature			Date	Signature			Date	Signature	Date	Signature	Date

ADMISSION REQUIREMENTS: One of the following must be presented each school year:

HEALTH-CARE PROFESSIONAL'S STATEMENT: *I verify the immunization information above or attached to this form and have examined the above-named child within the past year and find that he/she is physically able to take part in the program.*

_____
Signature or stamp **Date**

OR

_____ **a signed and dated copy of a health-care professional's statement is attached.**

OR

_____ **Medical diagnosis and treatment conflict with my religious beliefs. I have attached a signed and dated affidavit stating this.**

This Corporation does not and shall not discriminate on the basis of race, color, gender, national origin, ancestry, age, religion, creed, disability, marital status, military status, veteran's status, sexual orientation, gender identity or gender expression in the administration of its educational policies, admission policies, scholarship program or other school administered programs.

DISCOVERY SCHOOL of SAN ANTONIO, INC.
STUDENT HEALTH FORM
2024 – 2025

CHILD'S NAME_____ M ____ F ____ DOB_____

ADDRESS_____
STREET CITY ZIP

PARENT/GUARDIAN _____ PRIMARY PHONE_____

SECONDARY PHONE _____

PARENT/GUARDIAN_____ PRIMARY PHONE_____

SECONDARY PHONE _____

EMERGENCY CONTACTS and AUTHORIZATION FOR MEDICAL ATTENTION

In case of an emergency in which a parent or guardian cannot be reached, please contact

NAME ADDRESS PHONE RELATIONSHIP

_____

In the event I cannot be reached or make arrangements for emergency medical attention at the time of illness or accident, I hereby authorize the person in charge to take my child to:

_____

DOCTOR ADDRESS ZIP PHONE

_____

HOSPITAL ADDRESS ZIP PHONE

I give Discovery School my consent to secure any and all necessary emergency medical care for my child as well for my health care provider to share any pertinent health care records for my child.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

MEDICAL INSURANCE INFORMATION Name of Insured: _____

Carrier _____ Policy # _____

SEVERE ALLERGIES: Please list any severe allergy. If no known allergy, please state that there are no known allergies.
This space may not be left blank. Additional information will be required for a severe allergy.

_____

SPECIAL CARE NEEDS: List any special dietary considerations; physical, developmental, neuro-diverse, psychological or behavioral diagnoses; any limitations or restrictions on activities; any special care needs requiring reasonable accommodations or adaptive equipment; or any symptoms or indications of potential health complications *(include existing or previous serious illnesses, injuries or hospitalizations during the last 12 months, any medication prescribed for long-term or continuous use)* **This space may not be left blank. If no dietary, developmental or behavioral diagnoses, limitations on activities, need for reasonable accommodation or adaptive equipment, or potential health conditions -- enter None**

_____

_____