METHODIST DAY SCHOOL

Medical Form

3900 Lexington Blvd., Missouri City, Texas 77459

Phone: 281-499-2581 Fax: 281-261-4194 www.fumcmc.org/methodist-day-school

2018-2019

NAME OF CHILD:_____ **DOB:**_____

ADMISSION REQUIREMENT:

One of the following must be on file when your child is admitted to Methodist Day School.

1. HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is able to take part in the Day School program.

_____ _____

HEALTH CARE PROFESSIONAL'S SIGNATURE **DATE**

Name and address of health care professional: _____

_____

2. A signed and dated copy of a health care professional's statement is attached.

3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this. (Must have pre-approval of Day School Board)

_____ _____

SIGNATURE - PARENT OR LEGAL GUARDIAN **DATE**

IMMUNIZATION RECORD:

◊ I have provided the Methodist Day School with a copy of my child's most current immunization record.

VISION/HEARING REQUIRED FOR CHILDREN AGES 4 AND OLDER

VISION	**R 20/_____**	**L 20/_____**		☐ PASS ☐ FAIL

Screener Signature:_____ **Date:**_____

HEARING	**1000Hz**	**2000HZ**	**4000Hz**	
R				☐ PASS ☐ FAIL
L				☐ PASS ☐ FAIL

Screener Signature:_____ **Date:**_____