MEDICAL INFORMATION / EMERGENCY MEDICAL AUTHORIZATION:

In the event that I cannot be reached to make arrangements for emergency medical authorization,
I authorize Grace Crossing Academy or person in charge to take my child to:

(Name of Doctor)	(Doctor's Address)	(Phone Number)
(Name of Dentist)	(Dentist's Address)	(Phone Number)

Name of Insurance Co.: _____Phone() _____

Company Policy #: _____

Hospital Preference:_____

Does child take any medication on a regular basis?_____ If yes, what? _____

I give consent for this facility to secure any and all necessary emergency medical care for my child.

Parent Signature_____Date_____

ALLERGIES/DIETARY RESTRICTION:

Does your child have any allergies? Y / N Does your child have dietary restrictions? Y / N

Allergies*_____EpiPen Required? Y/N

*This written document outlines recommended treatment in case of an allergic reaction, signed by a child's physician and includes emergency contact information. It should be on file for every student with food allergies.

Dietary Restriction**:_____

Specific Insects _____EpiPen Required? Y / N

Specific Food _____

Skin: _____ Medicines: _____ Other: _____

**This written document outlines recommended treatment in case of a reaction, signed by a child's parent and includes emergency contact information. It should be on file for every student with dietary restriction.

CHILD'S PERSONAL HISTORY:

Child's Name: _____

Living Arrangements:

Parents: Both_____ Mom (Name)_____ Dad (Name)_____

Married_____ Separated_____ Divorced_____ Single_____

Grandparents_____ Guardian_____ Stepfather_____ Stepmother_____

MANDATORY: (If court ordered visitation applies, please provide copies of court documents concerning custody, guardianship, visitation, etc.)

105 FM1488 Road
Conroe, Texas 77384
(936) 442-5700
FAX: (936) 442- 5788

Grace Crossing Academy
Early Education Center

DOCTOR'S STATEMENT OF HEALTH
REQUIRED ONCE A YEAR

Child's Full Name: _____

Date of Birth: _____

I have examined the above-named child within the past year and find that he/she is physically able to take part in an early learning center program.

_____
Health Care Professional's Signature

_____
Address

_____
Date

If the child is four or older,
please write down the results of his/her hearing and vision screening:

Vision	R 20/	L 20/	Pass	Fail
Signature:				
Hearing	1000 Hz	2000 Hz	4000 Hz	Pass
R				
L				Fail
Signature:		Date:		

******PLEASE attach a copy of this child's immunization record and return to parent or school******