

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) _____

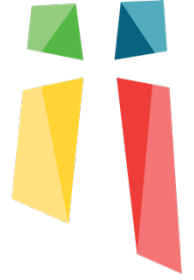
Married _____ Separated _____ Divorced _____ Single _____

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 Fail
R				
L				
Signature: _____		Date: _____		

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