

Physician Health Examination Form  
To be filled out by Parents:



Student Name:	Age:
Parent(s) Names:	Phone:
Address:	City, State, Zip:

I give permission for the physician listed below to exchange information regarding my child's medical needs with The Joy School staff.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

To be filled out by Physician:

Physician Name:	License #:
Address:	City, State, Zip:
Phone #:	

Vision Screening: <b>ALL GRADES</b> Right Eye 20/_____ Left Eye 20/_____ With Correction/Glasses: yes ___ no ___	Hearing Screening: <b>ALL GRADES</b> Pass _____ Fail _____
Spinal Screening: <b>(GRADE 5,6,7,8):</b> Normal _____ Scoliosis _____ Kyphosis _____ Other _____	ANTES Risk Factor Assessment <b>Grade 1,3,5,7</b> Date of Birth _____ Sex _____ Race/Ethnicity _____ Weight (lbs.) _____ Height (in.) _____ AN? Yes _____ No _____ BP (1 <sup>st</sup> measure) _____ BP (2 <sup>nd</sup> measure) _____

I have examined this patient and have found them to be in good physical condition with no communicable diseases. This patient's immunizations are up to date. **(Please included updated immunization record)**

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date:

# Family Directory Form

The Joy School prints a family directory each fall. It is for the purpose of communication among members of The Joy School Community. The use of the school directory is restricted to noncommercial, private use. Use of the school directory for any other purpose is prohibited. The Joy School does not make the directory available to any person for purposes not related to The Joy School community. With this being said, we would like to include the information you would like to represent your family in 2011-2012 directory.

Please write neatly ☺

Student' Name	
<b>Mother's information</b>	<b>Father's Information</b>
Name:	Name:
Address:	Address:
City and Zip:	City and Zip
Home Phone Number:	Home Phone Number:
Cell Number:	Cell Number:
Work Phone Number:	Work Phone Number:
Email Address:	Email Address:



# PARENT EMPLOYMENT INFORMATION

Parents/Guardians to complete and return to:

*The Joy School - Front Desk*

*One Chelsea Boulevard*

*Houston, TX 77006*

*713-523-0660 ext. 121*

*713-523-5660 (fax)*

Student's Name \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Email: \_\_\_\_\_

Business or Organization Name: \_\_\_\_\_

Position: \_\_\_\_\_

Business Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Email: \_\_\_\_\_

Business or Organization Name: \_\_\_\_\_

Position: \_\_\_\_\_

Business Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician Medication Form

This form is required for medications requiring  
Daily or prolonged use for longer than 15 school days.



To be Filled out by Parents:

Student Name:	Age:
Parent(s) Names:	Phone:
Address:	City, State, Zip:

I give permission for the physician listed below to exchange information regarding my child's medical needs with The Joy School staff.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

To be filled out by Physician:

Physician Name:	License #:
Address:	City, State, Zip:
Phone #:	

Name of Medication:	Dosage Instructions: <b>TJS Medication dispensing times 11:15-12:15 and 2:15-3:00</b>
Indications:	Possible Side Effects:

I have examined this patient and found them to be in good physical condition with no communicable diseases. This patient's immunizations are up to date. (Please include immunization record)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Any additional comments: \_\_\_\_\_

## OVER THE COUNTER PERMISSION FORM

Student Name: \_\_\_\_\_

Student Date of Birth: \_\_\_\_\_

Student's current weight: \_\_\_\_\_

The Joy School has permission to administer the following over the counter medications to my child.

Medication	Formula	Dosage
Tylenol	Adult	
	Children's	
Advil/Motrin	Adult	
	Children's	
Pepto Bismol	Chewable	
Benadryl	Adult	
	Children's	

Please indicate on this form any known allergies, either to foods, or natural substances.

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Any additional medical information?

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**Please remember:** We cannot administer any over the counter medications without permissions from the child's parent. If your child presents at the front desk requesting medication, we will make a call to you to authorize dispensing of the medication. This would include cough drops, cough medication, and eye drops. If you send over the counter medication please send specific directions and a signed permission slip. All medication must be dropped off at the front desk. Students are not permitted to keep any medication with them in class.

Parent Contact information: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

**EMERGENCY INFORMATION**

Date \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ Age \_\_\_\_\_

Weight \_\_\_\_\_ Are immunizations up to date?  Y

Height \_\_\_\_\_  N

Please list 8 people (and their phone numbers) to call in the event of an emergency. We would prefer parents be listed first, with the most likely numbers to reach them during the school day.

Home = H  
Office = O  
Cell = C

Name	Phone	Relationship
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____
7	_____	_____
8	_____	_____

**INSURANCE INFORMATION**

Company: \_\_\_\_\_

Group ID: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

**HOSPITAL INFO**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Location: \_\_\_\_\_

**PEDIATRICIAN INFORMATION**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address of Pediatrician: \_\_\_\_\_

**MEDICATIONS** Please list ALL medications currently taken (use the back of this form if more space is needed)

Name of Rx	Dosage Amt	Dosage Time & Frequency	Purpose of Medication	Prescribing Physician	Emergency # for Prescribing Physician
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**PERMISSION TO TRANSPORT**

In the event that I cannot be reached to arrange for emergency medical attention, I authorize the faculty and staff members of The Joy School to either contact emergency services via 911, or to transport to a healthcare facility.

Signature of Parent \_\_\_\_\_

Date \_\_\_\_\_

If I cannot be reached, I ask that the following be done:

Please list three topics of interest that we could use to talk with your child to "keep his mind off" of the emergency at hand:

Allergy information: