



UNIVERSITY
METHODIST PRIMARY SCHOOL

MEDICAL INFORMATION FORM 2026-2027

Return to office or email to marshall@universitysatx.org by May 1, 2026.

CHILD'S NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____

PARENTS' NAMES _____ EMERGENCY PHONE _____

IN THE EVENT THAT I CANNOT BE REACHED TO MAKE ARRANGEMENTS FOR EMERGENCY MEDICAL ATTENTION AT THE TIME OF AN ILLNESS OR ACCIDENT, I HEREBY AUTHORIZE THE DIRECTOR, PERSON IN CHARGE, OR EMS TO TAKE THIS CHILD TO THE PHYSICIAN AND /OR HOSPITAL NAMED BELOW.

SIGNATURE OF PARENT / LEGAL GUARDIAN

DATE

TO BE COMPLETED BY PHYSICIAN

IMMUNIZATION HISTORY: TEXAS LAW (H.B. 106 & 1316) REQUIRES THAT ALL CHILDREN ADMITTED TO CHILD CARE INSTITUTIONS SHALL BE IMMUNIZED AGAINST THE DISEASES LISTED BELOW. CHILDREN MAY BE PROVISIONALLY ADMITTED IF IMMUNIZATIONS ARE BEGUN AND CONTINUED AS RAPIDLY AS MEDICALLY POSSIBLE. IF CERTAIN DOSES ARE NOT GOING TO BE ADMINISTERED TO YOUR CHILD, PLEASE HAVE DOCTOR INDICATE SO BELOW.

OFFICIAL IMMUNIZATION RECORDS MAY BE ATTACHED TO THIS DOCUMENT.

	DATE	DATE	DATE	DATE	DATE
DTP/DTaP	_____	_____	_____	_____	_____
OPV/IPV	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
PCV	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
HEP A	_____	_____	_____	_____	_____
HEP B	_____	_____	_____	_____	_____
VARICELLA	_____	_____	_____	_____	_____

ALLERGIES

LIMITATIONS

ACTIVITIES CHILD SHOULD NOT ENGAGE IN:

OUTDOOR SPORTS / GAMES _____

OTHER LIMITATIONS _____

CHILD SHOULD WEAR:

HEARING AID _____ GLASSES _____ OTHER _____

STATEMENT OF EXAMINATION required by Minimum Standards – Between September 1, 2025 – September 1, 2026

THIS CHILD WAS EXAMINED BY ME ON THIS DATE, _____, AND FOUND TO BE FREE OF ALL CONTAGIOUS AND TRANSMISSABLE DISEASES AND IS PHYSICALLY ABLE, WITH EXCEPTIONS NOTED, TO PARTICIPATE IN THIS PROGRAM.

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME

ADDRESS (INCLUDE ZIP)

PHONE NUMBER

INSURANCE/MILITARY

HOSPITAL (FOR EMERGENCY) NO PREFERENCE

HEARING AND VISION ON BACK OF FORM; REQUIRED FOR CHILDREN AGES 4-10.

VISION SCREENING REPORT

Required each year for children who are turning 4, 5, 6, 7 and 8
Chapter 36 of the Health and Safety Code for children enrolled in a licensed childcare center in Texas
(Physicians may choose to attach their own form with these results)

CHILD'S NAME _____ AGE _____ DATE OF BIRTH _____

WITH CORRECTION:

- ☐ YES
☐ NO

NEAR VISUAL ACUITY:

OD 20/_____
OS 20/_____
OU 20/_____

CHART USED:

- ☐ LETTER
☐ "E"
☐ S.G.
☐ MACHINE

FAR VISUAL ACUITY:

OD 20/_____
OS 20/_____
OU 20/_____

RESULT:

- ☐ PASS
☐ FAIL

HEARING SCREENING REPORT

Required each year for children who are turning 4, 5, 6, 7 and 8
Chapter 36 of the Health and Safety Code for children enrolled in a licensed childcare center in Texas
(Physicians may choose to attach their own form with these results)

1. SCREEN FOUR FREQUENCIES AT 25dB HTL.
2. MAKE A CHECK MARK FOR EACH TONE HEARD.
3. IDENTIFY FAILURE TO RESPOND WITH AN "F" OR "X".
4. PLEASE NOTE SEQUENCE OF TONE PRESENTATION.

	RIGHT	LEFT
1 st - 1000 Hz		
2 nd - 2000 Hz		
3 rd - 4000 Hz		
4 th - 500 Hz		

☐ PASS ☐ FAIL

DATE OF SCREENING: _____

DATE OF SECOND SCREENING, IF NECESSARY: _____

REMARKS: _____