Wildwood Christian Academy

Mailing Address: 6606 FM 1488 Ste.148-505 Magnolia, Texas 77354
Physical Address: 8911 FM 1488 Magnolia, Texas 77354
Office Number: 832-934-0200

Medical Release and Immunization Record – 2023-2024 School Year

Your child's physician must complete this medical release form and attach an official immunization record that includes a doctor's signature or stamp. In order for your child to attend Wildwood Christian Academy, these documents must be on file.

Please ask your physician to complete the following questions:

Child's Name_____ **Date of Birth**_____/_____/_____ has been examined by a licensed physician and is able to participate in a weekday school program. Are there any restrictions from normal activities? _____yes _____no If yes, please explain:_____
_____

State standards and school policy require the examination must occur within 12 months of the start of school. Date of last examination? _____/_____/_____Age September 1, 2023? _____

Physician's Signature or Stamp_____ **Date**____/____/____

Physician's Phone Number_____ Fax Number_____

Physician's Address_____

An official immunization record must be attached to this form and returned in person or via email to Wildwood Christian Academy no later than the student's first day of school. The official immunization record must include a health-care professional's signature or stamp.

If a child is exempt from immunization requirements for a medical reason or reason of conscience, including a religious belief, a notarized affidavit from the Department of State Health Services must be attached, no later than the student's first day of school.

PARENT OR GUARDIAN: PLEASE COMPLETE ADDITIONAL MEDICAL INFORMATION ON BACK OF THIS FORM

Medical History

Has your child been hospitalized in the past 12 months? Yes No
If yes, please explain:

Does your child have an existing illness or medical concern? Yes No
If yes, please explain:

Does your child take an ongoing medication (prescription or over the counter)? Yes No
If yes, please explain:

Emergency Care Authorization

I certify that I am a parent or legal guardian of the child named above and give consent for emergency medical care, surgical treatment, and/or transportation to a care facility should my child's condition require it in my absence. I understand that, time and condition permitting, reasonable attempts will first be made to contact me and any emergency contacts in such a case. I hereby assume all financial responsibility for such actions taken on behalf of my child.

Insurance Company _____

Insurance Verification Phone Number _____

Group Number _____ **Policy Number** _____

Insurance Holder's Employer _____

Parent or Guardian Signature_____ **Date**____/____/____