FORT WORTH ACADEMY OF FINE ARTS
Texas Center for Arts + Academics

MEDICAL CERTIFICATE 2023-2024

required each school year

Due: First Monday in August of each school year (please notify the nurse otherwise)

This section to be completed by Parent/Guardian Is Student NEW to FWAFA ☐ Yes ☐ No

Student Name _____ Date of Birth _____ Grade _____
Last First Middle Month/Day/Year

Address _____ Birth Gender ☐ Male ☐ Female

Parent/Guardian _____ Contact Number (_____) _____

Parent/Guardian _____ Contact Number (_____) _____

1. Immunization – A copy of Immunization Records is **ONLY REQUIRED** for **NEW STUDENTS and those incoming 7th graders**. Immunization records must indicate the month, day, and year of each Series and Boosters and reflect the medical facility, as required by Texas Department of Health. All immunizations must be current or attendance will be denied.

My student had varicella disease (chickenpox) on or about _____ and did not need the varicella vaccine.
Month//Day//Year

Please do not leave empty SPACES (use dash (--) or N/A)

2. Health History – Today's Date _____

Food Allergies _____ Drug Allergies _____

Environmental Allergies _____ Heart Conditions _____

Orthopedic Conditions _____ Seizure Disorder _____

Emotional/Psychological/Behavioral Concerns _____

Diabetes ☐ Yes ☐ No Asthma ☐ Yes ☐ No Attention Deficit ☐ Yes ☐ No Glasses &/or contacts☐ Yes ☐ No

Other previous injuries, illnesses, surgeries _____

List all routine medications _____

_____

A **MEDICAL ALERT** for medical conditions that school personnel, such as teachers, need to be alerted to will appear in the teachers' portal of Ascender (FWAFA's student data base).

3. Administering Medication –

During the School Day –The following medications (or generic equivalent) may be utilized for my child:

Ibuprofen ☐ Yes ☐ No Acetaminophen ☐ Yes ☐ No Antacid tablets (Calcium Carbonate) ☐ Yes ☐ No

Diphenhydramine Cream ☐ Yes ☐ No Menthol cough/throat drops ☐ Yes ☐ No Antibiotic Cream ☐ Yes ☐ No

Parent Name _____ **Parent Signature** _____

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_____

Please print student's Last name First name

Off Campus Extended &/or Overnight Travel – I give my consent for my child to be administered (per packaging directions) the following non-prescription medications(s) or its generic equivalent by the school staff or designee(s)

□ Yes □ No -Antiseptic wipes followed by triple antibiotic ointment and a Band-Aid daily until healed PRN minor cuts

□ Yes □ No -Acetaminophen 500mg tabs, 1 or 2 tabs PO Q4h PRN headache or fever

□ Yes □ No -Ibuprofen 200 mg tabs, PO Q4h PRN strain, sprain, muscle aches, menstrual cramps, or dental pain

□ Yes □ No –Cough/throat Menthol (Honey/lemon flavor) lozenges

□ Yes □ No -Diphenhydramine 25 mg cap, 1 PO Q4-6h PRN allergic reaction (generic Benadryl)

□ Yes □ No -Calamine lotion applied to affected areas PRN heat rash or insect bites

□ Yes □ No -Sunscreen SPF 25-30 PRN applied to exposed skin for prolonged exposure to sun

□ Yes □ No -Sunburn relief

□ Yes □ No -Antacid tablets (Calcium Carbonate) USP 1000 mg.

□ Yes □ No -Stool Softener – Docusate Sodium 100 mg.

□ Yes □ No -Swimmer's Ear – Drops

□ Yes □ No –Off spray

Other medication(s) (prescription or otherwise) required by the student during school related or extended travel must be supplied by the parents and turned in in the original container, properly labeled, with the name of the student and identification of the medication, the dosage, and the time to be administered by the school staff or designee.

Parent Name _____ **Parent Signature** _____

This section to be completed by PHYSICIAN (must be within the current year)

Physical Examine Date _____

Height _____ Weight _____ Blood Pressure _____ Vision: Right _____ Left _____

	Negative	Positive		Negative	Positive
Skin	_____	_____	Abdomen	_____	_____
Head	_____	_____	Genitalia	_____	_____
Eyes, Ears, Nose	_____	_____	Extremities	_____	_____
Mouth, Throat	_____	_____	Joint Function	_____	_____
Neck	_____	_____	Spine-Scoliosis	_____	_____
Lungs, Chest	_____	_____	Kyphosis	_____	_____
Heart	_____	_____	Lordosis	_____	_____
Hearing	_____	_____	Vision	_____	_____

Date of first menstrual period _____ Date of last menstrual period _____

Explain any abnormal findings _____

I certify that on this date I have examined the above student as indicated by items marked and I recommend him/her as physically able to participate in supervised activities: Trips □ Yes □ No Campouts □ Yes □ No

All Sports/PE □ Yes □ No Swimming □ Yes □ No Dance □ Yes □ No

Exceptions _____

Physician's printed name (legible, please) _____

Signature of Examining Physician _____ Phone (___) _____or Clinic stamp