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

MEDICAL CERTIFICATE 2024-2025

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

Is Student in CCT, SGT, TBC (please circle applicable)

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 INCOMING 7th graders**. Immunization records must indicate the month, day, and year of each Series and Boosters and reflect the student's name, date of birth, and medical facility, as required by the Texas Department of Health.

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

Asthma ☐ Yes ☐ No **If YES**, what is the severity: *intermittent, mild, moderate, severe, persistent* (circle applicable)

What are asthma triggers? _____

Have you completed either form: Parent/Physician Request for Administration of Medication by School Personnel or Self-Administration of Prescribed Asthma of Anaphylaxis Medications by Student ☐ 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 database).

All medication(s) (prescription or over-the counter) needed or required by the student during school or school related activity must be **supplied by the parents and accompanied by appropriate form (**Parent/Physician Request for Administration of Medication by School Personnel**).** All medications will be locked in the nurse's office. Non-prescription medications must be in their original, properly labeled container. Prescription medications must contain a current pharmacy label.

Parent Name _____ **Parent Signature** _____

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_____

Student's Last name Student's First name

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