

Must Be Completed Each School Year

817-926-0750

Child's Name		Date of Birth		Home Telephone	
Child's Address		Zip Code		Family Email Address	
Mother's Name (and Address if Different from Child)			Father's Name (and Address if Different from Child)		
Mother's Company		Work Phone #:		Father's Company	
				Work Phone #:	
Mother's Cell Phone #:			Father's Cell Phone #:		
How did you hear about us?			Religion / Home Church		

Emergency Contact Information

Emergency Contact Name		Phone W: C:		Relationship	
Emergency Contact Name		Phone W: C:		Relationship	
In addition to those named above, I hereby authorize Trinity Episcopal to allow my child to leave the school with the following persons: (babysitters, friends)					
Name		Phone W: C:		Relationship	
Name		Phone W: C:		Relationship	

Authorization for Emergency Medical Attention

In the event that I or my above named contacts cannot be reached to make arrangements for emergency medical attention, I give consent for Trinity Episcopal School to secure any and all emergency care for my child, and I further authorize the facility director or person in charge to transport my child to:

Name of Physician		Address:		Phone #:	
Name of Hospital		Address:		Phone #:	
List below ANY conditions, (dating from birth) that your child may currently have or have had in the past, (allergies, illness, injury, surgery) or medications prescribed for long-term use and any other information of which staff should be aware. If none please write NONE					

Check All that Apply:

<input type="checkbox"/> RECEIPT OF HANDBOOK: I acknowledge receipt and acceptance of the policies of the Trinity Episcopal Handbook.
<input type="checkbox"/> WATER ACTIVITIES: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give - my consent for my child to participate in Water Activities: <input type="checkbox"/> water table play <input type="checkbox"/> sprinkler play (Summer Fun)

I certify that all statements made above are true:

Signature of Parent or Legal Guardian			Date		
FOR OFFICE USE	Date of Admission	Date of Withdrawal	Days & Hours child will be in School		
			Teacher's Name:		

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Hearing and Vision Screening

The State of Texas requires that all four and five year children have a hearing and vision screening within 1 month of the start of school. Hearing and Vision screenings are recommended for 3-year-old children.

Please check one:

- My child's vision and hearing were tested at a physician's office and I will submit a copy of that test.
- My child has not been tested and will use the low cost service provided at the school.
- My child is two or three and does not require testing at this time.

Doctor's, Clinic, or Parent's Statement:

- This child **has been examined** within the past 12 months and found that he/she is physically able to take part in the Trinity Episcopal School program.
- This child **will be examined** in the next 12 months and the parent will submit a health form at that time.

Signature of Physician, Nurse, or Parent: _____ Date: _____

- If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign and notarize affidavit to that effect and attach it to this form.
- If immunization and /or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.

The following immunization information may be submitted on a separate form. If so please write, **"See Attached"** across this section.

Immunization	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 Yrs	4-6 Yrs	
Hepatitis A												
Hepatitis B												
Rotavirus												
Diphtheria, Tetanus, Pertussis												
Haemophilus Influenzae type B												
Pneumococcal												
Inactivated Poliovirus												
Influenza												
MMR												
Varicella												
Meningococcal												
TB TEST (If Required)	<input type="checkbox"/> Positive				<input type="checkbox"/> Negative				Date: _____			

Varicella (Chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete this statement. My child had varicella disease (Chickenpox) on or about _____ and does not need a Varicella vaccine. (Date)

I certify that all statements made above are true.

Signature: _____

Date: _____