HEALTH RECORD

Trietsch Enrichment Center Preschool 2019-20

Trietsch Memorial United Methodist Church 6101 Morriss. Rd. Flower Mound, Texas 75028
(972) 539-6491 Email: tec@tmumc.org

Child's Name:_____Sex:____ Date of birth:_____
Parent(s) Name:_____Phone:_____

PARENT AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In order to meet all legal requirements, I hereby authorize the staff of Trietsch Enrichment Center, to give consent for any and all necessary emergency medical care for my child, while my child is in their care. I will not hold the TEC staff or Trietsch Memorial UMC responsible for any accident or injury that might occur. Physician's Name: _____
Phone: _____ Address:_____

In an emergency, children will be transported to Flower Mound Presbyterian Hospital- 4400 Long Prairie Rd. Flower Mound, TX)

If you choose alternate hospital, notate here_____

List any allergies::_____
Severity of Allergy: circle one: *None Mild Moderate Severe*

Note: If your child has a known (and diagnosed) food allergy, you must provide a "Food allergy emergency plan" that has been signed and dated by the physician

THIS PHYSICIANS SIGNATURE NEEDED BELOW IS FOR NEW STUDENTS ONLY

Returning TEC students do not need a new physician's statement each school year. You are only required to have one physician's statement throughout the course of enrollment at TEC.

Parent must check one of the following below before your child can attend TEC:

1. ☐ My child has previously been enrolled at TEC, therefore all of the information below is currently on file
2. ☐ PHYSICIAN'S STATEMENT: I have examined this child within the past year and find that she/he is able to participate in Trietsch Enrichment Center Preschool and Kindergarten program and activities.

_____ _____
PHYSICIANS SIGNATURE DATE

3. ☐ A signed and dated copy of a physician's statement is attached.
4. ☐ My child has been examined within the past year by a physician and is able to participate in this program. **I will obtain a physicians signed statement and will submit it to TEC by the end of the semester, December 19th.**

Name of physician:_____*Address of physician*:_____

IMMUNIZATION RECORD *(Immunizations must be turned in before your child may start school)*

☐ I have provided TEC with a copy of my child's most current immunization record.

HEARING & VISION SCREENING IS ONLY REQUIRED FOR CHILDREN 4 AND 5 YEARS OLDS

VISION	R 20/_____	L 20/_____	☐ PASS	☐ FAIL
SCREENER SIGNATURE_____		DATE_____		
HEARING				
Right	☐ PASS	☐ FAIL		
Left	☐ PASS	☐ FAIL		
SCREENER SIGNATURE_____		DATE_____		

Signature of parent/guardian_____Date:_____