SCDC HEALTH RECORD

Child's Name: _____ Sex: M F Date of Birth: _____
First Middle Last Month Day Year

Address: _____
Street City State Zip

Mother's Name: _____ Telephone: _____
First Middle Last Home Work

Father's Name: _____ Telephone: _____
First Middle Last Home Work

IN CASE OF AN EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL:

**********AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION*********

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the SCDC Director or person in charge to take my child to:

Physician Name: _____ Physician Phone #: _____

Physician Address: _____

Hospital Name: _____ Hospital Phone #: _____

Hospital Address: _____

I give consent for this facility to secure any and all necessary medical care for my child.

_____
Parent or guardian signature Date

Choose and Complete One of the Following Items:

[ ] Doctor's Statement: I have examined the above named child within the past year, and find that he/she is physically able to take part in the SCDC Program.

Physician's Signature: _____ Date: _____

[ ] Parent's Statement: My child has an appointment for a physical examination, and I will submit the physician's statement to SCDC.

_____ _____
Name of Physician Address of Physician

_____ _____
Date of Appointment Parent's Signature/Date

Please attach a copy of the most updated shot record signed by the doctor to this form

A Doctor's signature is required to be on file by Texas State Law before your child starts school.