_____

Child's Name

I/we understand that this authorization is given in advance of any specific treatment or diagnosis, but is given to provide authority and power of treatment or hospital care which the aforementioned physician in the exercise of best judgment may deem advisable. This authorization is given pursuant to the provisions of Chapter 32 of the Texas Family Code. This authorization shall remain effective for up to one year from the date of completion of this form, unless sooner revoked in writing delivered to said agent(s).
Please check any of the spaces below which describe a health problem your child/ward has which might require attention. If your child has no such health problems, check "None of the Above".

- ☐ Allergies
- ☐ Blood disease (sickle cell anemia, aplastic anemia, malaria, hemophilia, etc.)
- ☐ Heart problems requiring limitations
- ☐ Diabetes
- ☐ Food Allergy requiring immediate attention
- ☐ Digestive disorder (ulcers, colitis, etc.)
- ☐ Hearing impairment or complete hearing loss
- ☐ Insect sting allergy – severe requiring immediate attention
- ☐ Malignancy (leukemia, sarcoma, Hodgkin's disease, etc.)
- ☐ Neurological problem (cerebral palsy, hydrocephalus, etc.)
- ☐ Orthopedic problem – severe requiring limitations (brittle bone disease, etc.)
- ☐ Respiratory problem – severe requiring limitations (asthma, cystic fibrosis, etc.)
- ☐ Seizure disorder (epilepsy, etc.)
- ☐ Urinary tract disorder (nephritis, absence of kidney or bladder, etc.)
- ☐ Vision impairment or complete vision loss
- ☐ None of the Above

Please check any past illnesses your child/ward has had and give the approximate dates.

- ☐ Chicken Pox
- ☐ Three-Day "German" Measles (Rubella)
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Whooping Cough
- ☐ Diabetes
- ☐ Ten-Day Measles (Rubeola)
- ☐ Mumps
- ☐ Asthma
- ☐ Hay Fever
- ☐ Poliomyelitis

Medications being taken: _____

Additional information/instructions (including serious or severe illness or accidents, known allergies, or special dietary considerations):

_____

_____

School policy requires that all children attending GCCA must show and maintain on file proof that they have been immunized for hepatitis A, measles, mumps, rubella (MMR),varicella, tetanus, diphtheria, acellular pertussis (Tdap), and meningococcal (7th grade), as well as hearing, vision, and spinal screening. Verification of these shots or a signed exemption waiver must be in GCCA office prior to the beginning of school.

We require permission from a parent/guardian before any medication will be administered to a student. Please indicate your preference by checking and signing the following statement.

I authorize the school to administer nonprescription medication (Tylenol or Tums) to my child/ward as needed:

☐ Yes ☐ No

Prescription medication will not be administered by the school without written permission from a parent/guardian.

In an emergency, parents will be contacted for immediate consultation. If parents cannot be reached and medical attention is needed, please initial the appropriate following statement:

_____ I hereby allow the faculty and staff of GCCA, including parents volunteering for transportation duties, to seek and secure emergency medical treatment for my child.

_____ I do not wish the faculty and staff of GCCA, including parents volunteering for transportation duties, to seek and secure emergency medical treatment for my child.