

HEALTH REQUIREMENTS

Name of Child:										Date of Birth:			
Age \blacktriangleright Vaccine \blacktriangledown	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 B													
Rotavirus													
Diphtheria, Tetanus, Pertussis													
Haemophilus influenzae type b													
Pneumococcal													
Inactivated Poliovirus													
Influenza													
Measles, Mumps, Rubella													
Varicella													
Hepatitis A													
Meningococcal													
TB TEST (if required)		<input type="checkbox"/> Positive		<input type="checkbox"/> Negative		Date:							
Signature or stamp of a physician or public health personnel verifying immunization information above. _____ (A copy of signed immunization may be attached _____ Signature _____ Date)													
Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.													
Parent's signature _____						Date _____							
<input type="checkbox"/> I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.													
For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/school_info.htm													

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

_____ Health Care Professional's Signature

_____ Date

2. A signed and dated copy of a health care professional's statement is attached.

3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

4. My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

_____ Signature - Parent or Legal Guardian

_____ Date

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____	DATE _____		
HEARING	1000 Hz	2000 Hz	4000 Hz
R			
L			
SIGNATURE _____	DATE _____		
			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL

Signature - Parent or Legal Guardian

Date