Medical Information 2018-2019

Child's Name _____ Date of Birth _____

Statement of Health:

I have examined the above named child within the past year and find that he/she is physically able to take part in the daycare program.

_____ _____

PHYSICIAN'S SIGNATURE **** **Date**

1. Allergies:

Please note any allergies, special needs or chronic conditions teachers and staff may need to be aware of:

_____

2. Immunizations:

You may submit a copy of an immunization record signed or stamped by physician or health personnel or complete the following:

Vaccine	Recommended Date	Date Given
Hep B	by 3 months	
	by 5-16 months	
	by 19-43 months	
DtaP	by 3 months	
	by 5 months	
	by 7-16 months	
	by 19-43 months	
Hib *	by 3 months	
	by 5-7 months	
	by 16-43 months	

Vaccine	Recommended Date	Date Given
IPV(polio)	by 3 months	
	by 5-16 months	
	by 19 -43 months	
MMR	by 12-43 months	
Varicella	by 12-43 months	
(or date of chickenpox disease)		
Hep A	by 12-25 months	
	by 43 months	
PCV **	by 3 months	
	by 5 months	
	by 7 months	
	by 16-43 months	

_____ _____

Signature or Stamp (if immunization filled out above) of Physician or Health Personnel

_____ _____

Signature of Parent or Legal Guardian **Date**

MANDATED SCREENING FOR FOUR YEAR OLDS:

Vision: With Glasses_____Without Glasses_____Passed_____Failed _____Referred_____

Hearing: Passed_____Failed_____Referred _____

Please return to **Creative School WHUMC** **10066 Marsh Lane** **Dallas, TX 75229**

Office: 214 352-0732 **Fax: 214 357-3753**