

# Medical Information 2021-2022

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	Vaccine	Recommended Date	Date Given
Hep B	by 3 months	_____	IPV(polio)	by 3 months	_____
	by 5-16 months	_____		by 5-16 months	_____
	by 19-43 months	_____		by 19 -43 months	_____
DtaP	by 3 months	_____	MMR	by 12-43 months	_____
	by 5 months	_____	Varicella	by 12-43 months	_____
	by 7-16 months	_____			
	by 19-43 months	_____	Hep A	by 12-25 months	_____
Hib *	by 3 months	_____	PCV **	by 3 months	_____
	by 5-7 months	_____		by 5 months	_____
	by 16-43 months	_____		by 7 months	_____
				by 16-43 months	_____

\_\_\_\_\_  
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 WHC  
Office: 214 352-0732**

**10066 Marsh Lane  
Fax: 214 357-3753**

**Dallas, TX 75229**