Medical Information 2017-2018

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 day care 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:

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2. Immunizations:

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

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

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