

Medical Information 2022-2023

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 school 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
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Hep B	by 3 months by 5-16 months by 19-43 months		IPV(polio)	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		MMR	by 12-43 months	
			Varicella (or date of chickenpox disease)	by 12-43 months	
			Hep A	by 12-25 months by 43 months years	
Hib *	by 3 months by 5-7 months by 16-43 months		PCV **	by 3 months by 5 months by 7 months by 16-43 months	

MANDATED SCREENING FOR FOUR YEAR OLDS:

Vision: With Glasses _____ Without Glasses _____ Passed _____ Failed _____ Referred _____

Hearing: Passed _____ Failed _____ Referred _____

+Parent or Legal Guardian Signature _____ **Date** _____

THIS FORM IS DUE IN THE SCHOOL OFFICE BY SEPTEMBER 1ST.

Creative School
10066 Marsh Lane
Dallas, TX 75229
FAX: 214-357-3753

