EARLY CARE & EDUCATION

Fax (214) 988-5132

Physician's Statement

Name of Child _____ Date of Birth _____

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

Health Care Professional Name _____

Address _____ City _____ State _____ Zip _____

Signature _____ Date _____

Age Vaccine	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mo	2-3 yrs	4-6 yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus Influenzae type B											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningocccal											

TB Test (if required) *please circle* Positive Negative Date _____

Signature or Stamp of a physician or public health personnel verifying immunization information above.

Signature _____ Date _____

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If you child has had chickenpox, please complete the statement: My child had varicella (chickenpox) on or about (date) _____ and does not need varicella vaccine.

Parent Signature _____ Date _____

Complete ONLY if Applicable

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.

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.

Parent Signature _____ Date _____

You don't stop playing because you grow old, you grow old when you stop playing