

HEALTH REQUIREMENTS

Name of Child:				Date of Birth:	
IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / booster	Date / booster
DTP / DTaP / DT					
POLIO IPV or OPV					
MEASLES Rubeola / Serampion					
MUMPS					
RUBELLA					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date:		
Varicella (see below)					

SEE ATTACHED COPY OF IMMUNIZATION RECORD

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

 Parent's signature _____
Date

Signature of Health Care Professional _____ Date _____

Signature of staff making handwritten copy of record _____ Date _____

ADMISSION REQUIREMENT: One of the following must be presented when your child (under the age of 5 years) is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

HEALTH-CARE PROFESSIONAL'S STATEMENT: 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.

_____ Date _____
Health Care Professional's Signature

A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.

A form or written statement from a health service or clinic.

If you do not have any of the above:

PARENT'S STATEMENT: My child has been examined within the past year by a health care professional and is able to participate in the day care program:

Name and address of health care professional:

Within 12 months of admission, I will obtain a health care professional's statement and will submit it to the day care facility.

OR

My child has an appointment for a physical examination:

Date: _____ Name and Address of health care professional: _____

I will submit the statement, from a health care professional to the child-care facility following the examination.

_____ Date _____
Signature - Parent or Legal Guardian

HEARING	DATE	SIGNATURE		
Hz	1000	2000	4000	PASS <input type="checkbox"/>
R				FAIL <input type="checkbox"/>
L				
VISION	DATE	SIGNATURE		
R20/	L20/			PASS <input type="checkbox"/> FAIL <input type="checkbox"/>

NOTE: If medical diagnosis and treatment and / or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and / or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a health care professional) to that effect and attach it to this form.