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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)	☐ Positive	☐ Negative	Date :		
Varicella (see below)					

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.

______________________________ Health Care Professional's Signature ______________ Date

☐ 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.

______________________________ Signature - Parent or Legal Guardian ______________ Date

HEARING	DATE		SIGNATURE	
Hz	1000	2000	4000	PASS ☐
R				
L				FAIL ☐

VISION	DATE	SIGNATURE		
R20/	L20/		PASS ☐	FAIL ☐

☐ **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.**