HEALTH REQUIREMENTS

Child's Name:				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 on 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 indelicate 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) OR Texas Health Steps 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:

Or

☐ 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.