Weekday Program Health Requirements

Must be completed and returned before the child begins school each year.

HEALTH REQUIREMENTS

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:*

_____ _____

Health Care Professional Signature ***Date***

Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	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											
Meningococcal											

TB TEST (if required) ☐ Positive ☐ Negative Date:

Signature or stamp of a physician or public health personnel verifying immunization information above. (Please attach the vaccine record to this form)

_____ _____

Signature or stamp of a physician or public health personnel **Date**

Chickenpox: Varicella is not required if your child has had chickenpox. Please complete the statement below:

My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

_____ _____

Parent's signature Date

Immunization Affidavit: 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 stated this.

_____ _____

Health Care Professional Signature Date

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

*CHILDREN **AGES 4 AND ABOVE** BY SEPTEMBER 1ST OF THE CURRENT SCHOOL YEAR, MUST HAVE VISION AND HEARING TESTS ON FILE BY NOVEMBER. (PLEASE ATTACH THE EXAMINATION RECORD TO THIS FORM)*

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL

_____ _____

Health Care Professional Signature / Stamp ***Date***

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

_____ _____

Health Care Professional Signature / Stamp ***Date***

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

Completed forms may be faxed to 972-633-9126. If you have any questions, call our office at 972-423-4910.