HEALTH REQUIREMENTS FORM 2018-2019

CHILD'S NAME: **DATE OF BIRTH:**

[ ] Attached is a copy of the Immunization Records for the child listed above. I understand that it is my responsibility to bring updated records to the office throughout the year as immunizations are administered.

[ ] I am implementing a delayed immunization schedule. I will supply a signed/dated note from the doctor stating the dates of the delayed schedule.

[ ] 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.

For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/school_info.htm

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 signature and date

ADMISSION REQUIREMENT: One of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. [ ] A Doctor's statement is attached.

2. [ ] DOCTOR'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.

_____ _____
Doctor's Signature Date

3. [ ] My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

_____
Doctor's name/Doctor's address / Doctor's phone number

4 YEAR OLDS ONLY (please check only one option):

[ ] I have attached a copy of the hearing and vision screening results for the above named child.

[ ] Results for the hearing and vision screening are as follows:

VISION: **R** 20/_____ **L** 20/_____ **[ ]PASS** **[ ]FAIL**

HEARING: **1000HZ** **2000HZ** **4000HZ**

R: _____/_____/_____ **[ ]PASS** **[ ]FAIL**

L: _____/_____/_____

_____ _____
Doctor's Signature Date

I acknowledge that the above/attached information on this entire page is true and correct to the best of my knowledge.

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