Certificate of Health
& Immunization Record

To be completed by parent/guardian

Child's Name	Birth Date	Address	Phone Number
Parent's Name		Address	Phone Number
Physician's Name		Address	Phone Number
Dentist's Name		Address	Phone Number

Disease History	Date
Whooping Cough	
Rubella	
Chicken Pox	
Mumps	
Measles	
Operations	**Date**
Tonsillectomy	
Adenoidectomy	
Appendectomy	
Mastoidectomy	
Tubes in Ear	

Immunizations						
Required	**1st**	**2nd**	**3rd**	**4th**	**5th**	**6th**
DTP or TD						
Polio						
Hepatitis B						
Hib						
MMR						
Varicella						

Optional	Date
Small Pox	
Flu	
Typhoid	

NOTE: If a physician does not sign this statement, submit other proof of immunization signed by physician.

Are there any restrictions on normal physical activities indicated but not limited to existing illness, previous serious illness or injury? Yes____ No____	If yes please specify.
Does the child have any chronic medical condition necessitating dietary supplements or restrictions, medications prescribed for continues or long term use, or avoidance of allergies? Yes____ No____ If yes please specify: If your child's doctor has created a food allergy emergency plan please submit it with this form or fill out the specifics to the right.	List Allergy(s): Possible Symptoms: Steps to take in case of an allergic reaction:
Has the child been hospitalization during the past 12 months Yes____ No____	Special attention required.

___I certify that my child is enrolled in a regular medical program and has been examined by a doctor within the last 12 months.

To be completed by a physician

The above named child is now free of any infectious or contagious Disease and has my permission to attend school. This child is medi-cally__up to date __not up to date with immunization. If not now up to date, immunization can be made up in _______months.

Comment____
____
____

Physician's Signature Date

___I certify that the immunization record is on file at the elementary school my child attends.

___I understand that if my child does not have a current shot record then I must submit a notarized "Exemption from Immunizations for Reasons of Conscience" before my child may be enrolled.

Note: All children must be examined by a licensed physician or practitioner within the last 12 months. If this form is not signed by a physician, above boxes must be checked.

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Parent's Signature Date

Attention Parents-Important!

1. A child who appears ill upon arrival shall not be admitted to child care center.
2. When a child becomes ill at the center, the parents shall be contacted and arrangements made for the child to be picked up immediately. This determination will be made by the center
3. The center may require a physician's statement prior to readmitting your child to the center following an illness.
4. At the time of registration, the parent should authorize the child physician to accept all calls from the child care director for emergency medical care.

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Parent's Signature Date